

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH DAY YEAR			MONTH	DAY	YEAR	2b. HOUR				
BAISY			LEE	ASHFORD		8	13	1916	4	12	83	8:12 A				
3. SEX			Male	RACE	White	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 MRS.		
						MONTH	DAY	YEAR	66	YRS.		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			Virginia	7b. CITIZEN OF WHAT COUNTRY?			USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
10. CITY OR TOWN OF DEATH			Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Retired	12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE			Maryland	13b. COUNTY			Harford	13c. CITY OR TOWN			Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
															717 Schofield Road 21001	
14. FATHER'S NAME			Jesse	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
			C.	Ashford					Ethel		Meredith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			Yes	16b. SOCIAL SECURITY NO.			WW-II	17. INFORMANT			ADDRESS					
							226-16-1295				Maryland 21001					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cerebral embolism										9 days			
4341 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DOUE TO, OR AS A CONSEQUENCE OF (b)																
DOUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): obstructive lung disease																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE					
									4-12	19	83					
22a. I certify that (I) (this hospital) attended the deceased from 4-12 19 83 to 4-12 19 83, that (I) (we) last saw the deceased alive on 4-12 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			B. J. Plunkett Jr			DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			BARRY J Plunkett							4-12-83						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
Burial			04/16/83			Bel Air Memorial Gdn's Bel Air Harford Maryland										
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399									APR 18 1983							

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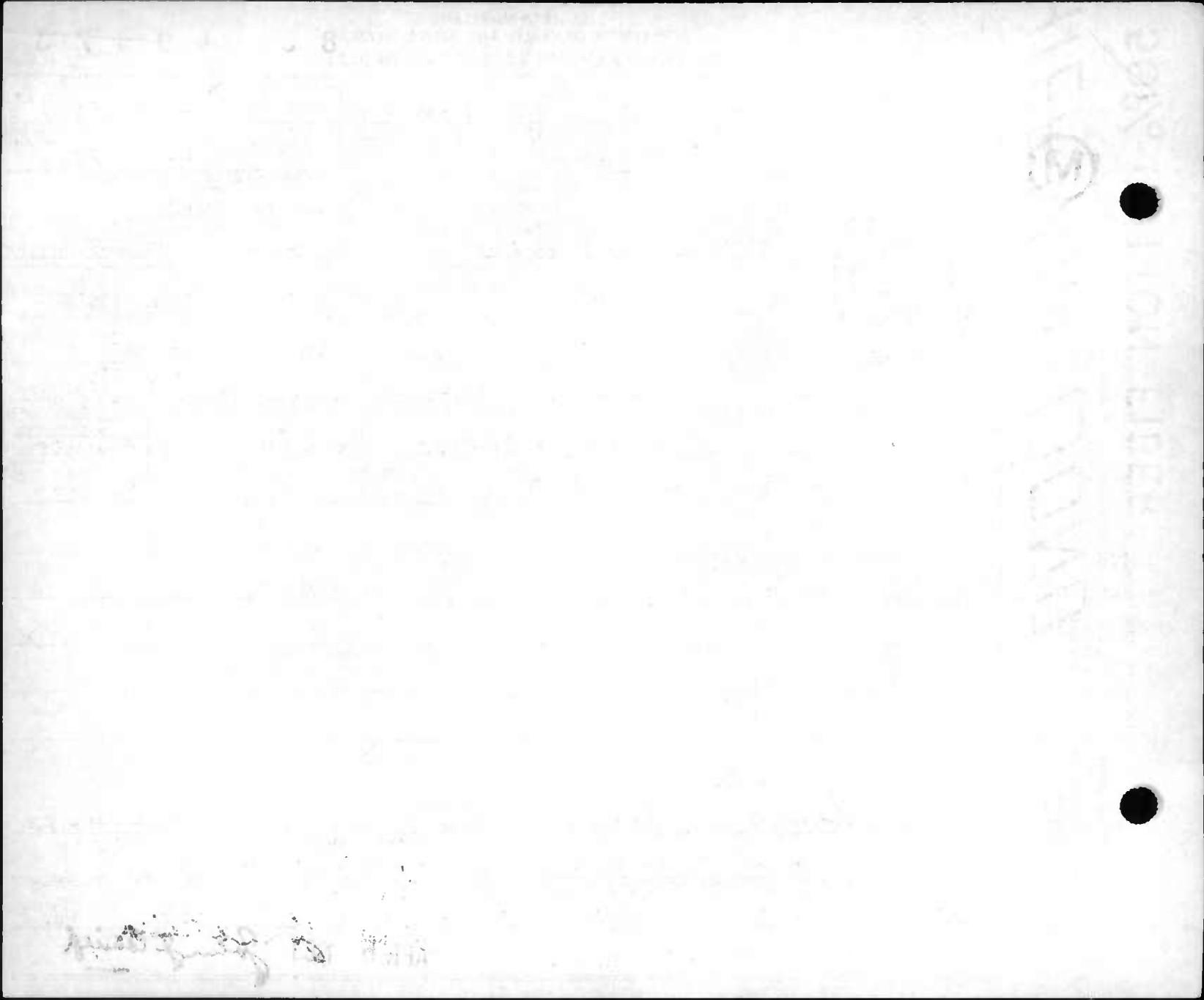
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTHYGNE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8310673			
1 - STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR 3:07 P.M.		
John Leonard Bartkowiak								<input checked="" type="checkbox"/>		4	4	1983			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR 3:07 P.M.	
M		W		5 - 16 - 22		60						4 - 4 1983			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED WIDOWED		7d. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA		<input type="checkbox"/>		<input checked="" type="checkbox"/>		Harford County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Fallston		Fallston General Hospital		Nurseryman		Flower-Nurser									
SPECIAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
10. STATE		11b. COUNTY		11c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Harford		Churchville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		430 Priestford Road		21028					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Henry		Stanley		Bartkowiak		Frances		Mary		Budzynski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		220-30-6181		Mrs. Frances Kahl, 4828 Forge Rd, Perry Hall		Md. 21128									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Sudden Cardiac Death</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>A.S.C.V.D.</u> (c) <u>Years</u>															
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Samuel H. Henck</u>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER 721 Wheeler School Rd.		DATE SIGNED 4-4-83									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS White Ford, Md. 21160													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 7, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN Bel Air		23e. COUNTY Harford		23f. STATE Md.					
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 6 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Cawley</u>									

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifier must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)												8310674				
FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
FRANK			E.			Beck, Sr.			April 22						10 ¹ .M	
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			May 15 1898			84			MONTHS	DAYS	HOURS	MIN.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.						Harford							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Havre de Grace			Harford Memorial Hosp			Agent			B&O Railroad			21001				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13c. STREET ADDRESS				
			Maryland			Harford			IN Aberdeen			1928 Park Beach Dr.				
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME										
George			Beck			Carrie						LAST Krammer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			705-10-2495			Francis E. Beck, Jr. 1928 Park Beach Dr.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY 4100 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. { DUE TO, OR AS A CONSEQUENCE OF (b) and sick sinus syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-20 19 83 to 4-22 19 83, that (I) (we) last saw the deceased alive on 4-22 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>John Yun</i>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TITLE OR RANK) <i>John Yun</i>			22e. ADDRESS 508 S. Union Ave Havre de Grace													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 25, 1983			23c. NAME OF CEMETERY OR CREMATORIALy Holy Redeemer			23d. LOCATION CITY OR TOWN Baltimore			COUNTY		STATE Md.		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 25 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Ruck</i>							

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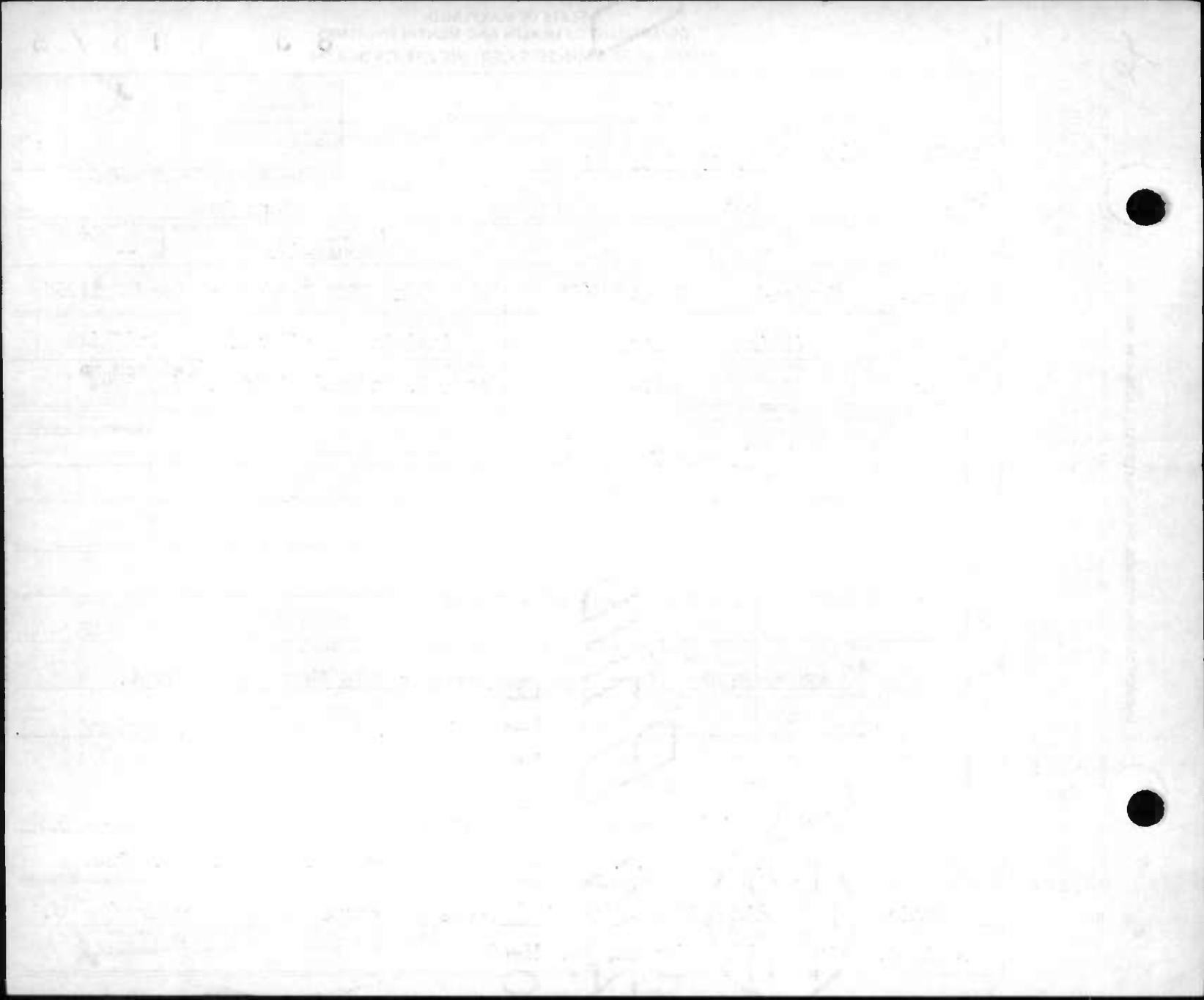
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGES 1, 3, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 1 0 6 7 5			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH MATED				MONTH	DAY	YEAR	2b. HOUR		
LINDA			MAE	BEDWELL		<input checked="" type="checkbox"/>	<input type="checkbox"/>	4	5	1983	M				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR 9:19 p.m.		
Female	White	Feb 22, 1952	31 yrs.			<input checked="" type="checkbox"/>	<input type="checkbox"/>	4	5	1983					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County								
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Hospital (DOA)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY --						
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2526 Sandy Hook Road		21050						
14. FATHER'S NAME FIRST Murdo		MIDDLE William	LAST Bennett	15. MOTHER'S MAIDEN NAME FIRST Virginia MIDDLE Mildred LAST Griffith											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-60-8234		17. INFORMANT Grady G. Bedwell, 1436 S. Phila Blvd 21001		ADDRESS Aberdeen, Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)}												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AMX MONTH DAY YEAR 8:30 P.M. 4-5-1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Occupant in auto that lost control.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET CITY OR TOWN Forge Hill Rd. near Deer Creek, Harford COUNTY Md. STATE									
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Ann M. Dixon</u>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201						DATE SIGNED 4-7-83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 9, 1983 Angel Hill Cemetery			23c. NAME OF CEMETERY OR CREMATORIUM Angel Hill Cemetery			23d. LOCATION CITY OR TOWN Havre de Grace		COUNTY Harford	STATE Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, ADDRESS Abingdon, Md. 21009									25. APR REC'D BY REGISTRAR APR REC'D BY REGISTRAR'S SIGNATURE APR 11 1983 <u>John J. Connelly</u>						

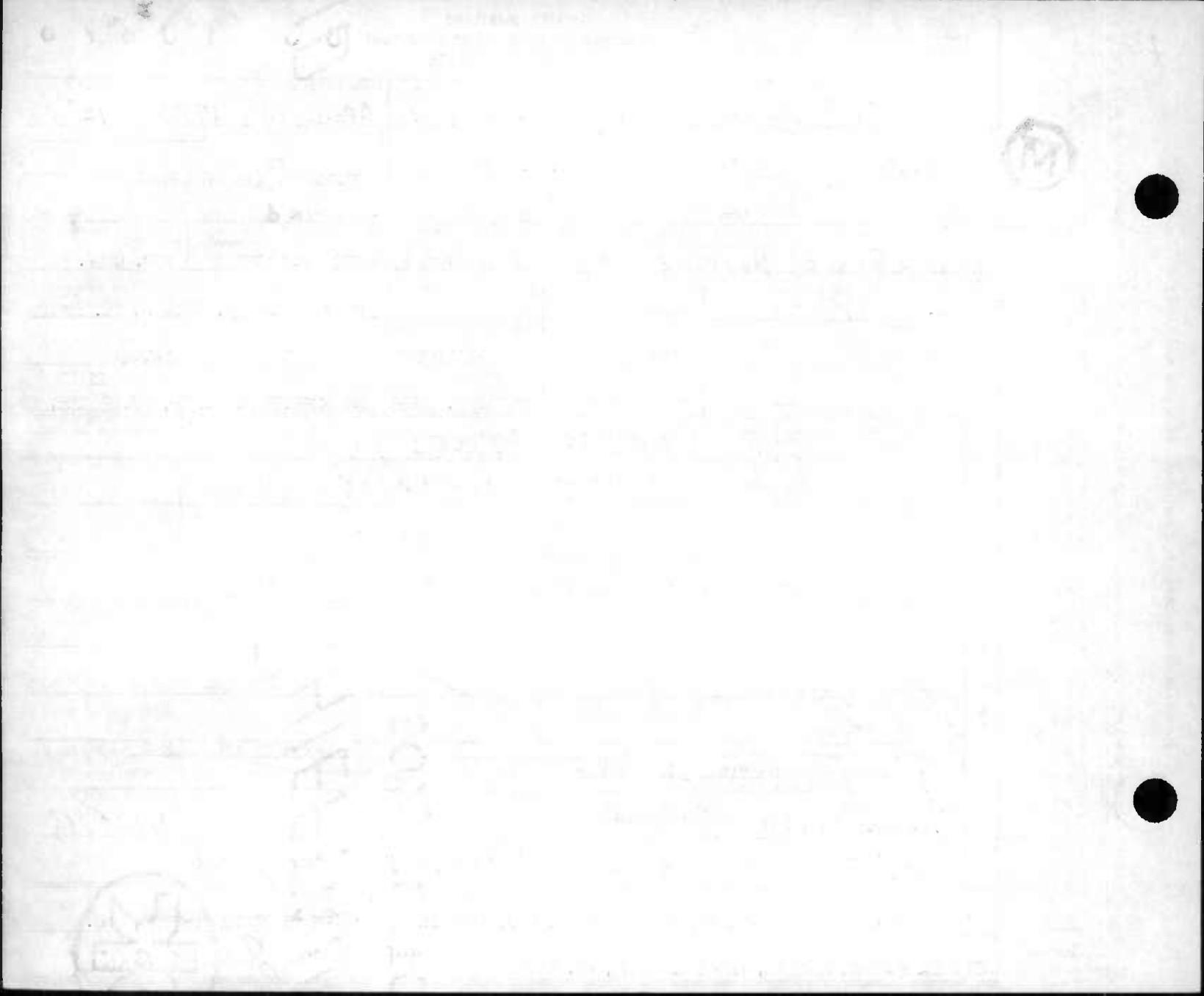


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the indicated physician must be certified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8310676		
												REG. NO.		
1 - STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>Georgia SAUNDERS</i>					<i>BenJamin</i>	<i>APRIL 19, 1983</i>						<i>12⁴⁶ PM</i>		
1. SEX			4 RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
FEMALE			WHITE			NOV. 16, 1898						IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS. HOURS MIN.		
MD			USA						<i>HARFORD</i>			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
<i>Havre de Grace</i>			<i>HARFORD Memorial Hospital</i>			(RET) SECRETARY			FED. GOVT.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
13a. STATE FLA.			13c. CITY OR TOWN MIRAMAR						3120 SW 65th AVE, MIRAMAR, FL 33023					
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST					
EDWARD				SAUNDERS	ELIZABETH					WALKER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			220 20 7379			MARTHA M. GRUBB			21122 241 WHEELER SCHOOL RD, PYLESVILLE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
+409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>ARTERIOSCLEROSIS</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>OLD AGE</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Anemia, Degeneration Rhinomalacia</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 11, 1983</i> , to <i>APRIL 19, 1983</i> , that (I) (we) last saw the deceased alive on <i>APRIL 19, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Dante Monarca</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>APR 19 83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANTE MONARCA</i>			22e. ADDRESS <i>Havre de Grace, Md</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE APRIL 22, 1983			23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY			23d. LOCATION CITY OR TOWN HAVRE DE GRACE, HARFORD, MD.					
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR APR 25 1983			REGISTRAR'S SIGNATURE <i>John J. Conigli</i>					
DHMH - 16 50M 4/B2 (VRA 15, 4)														

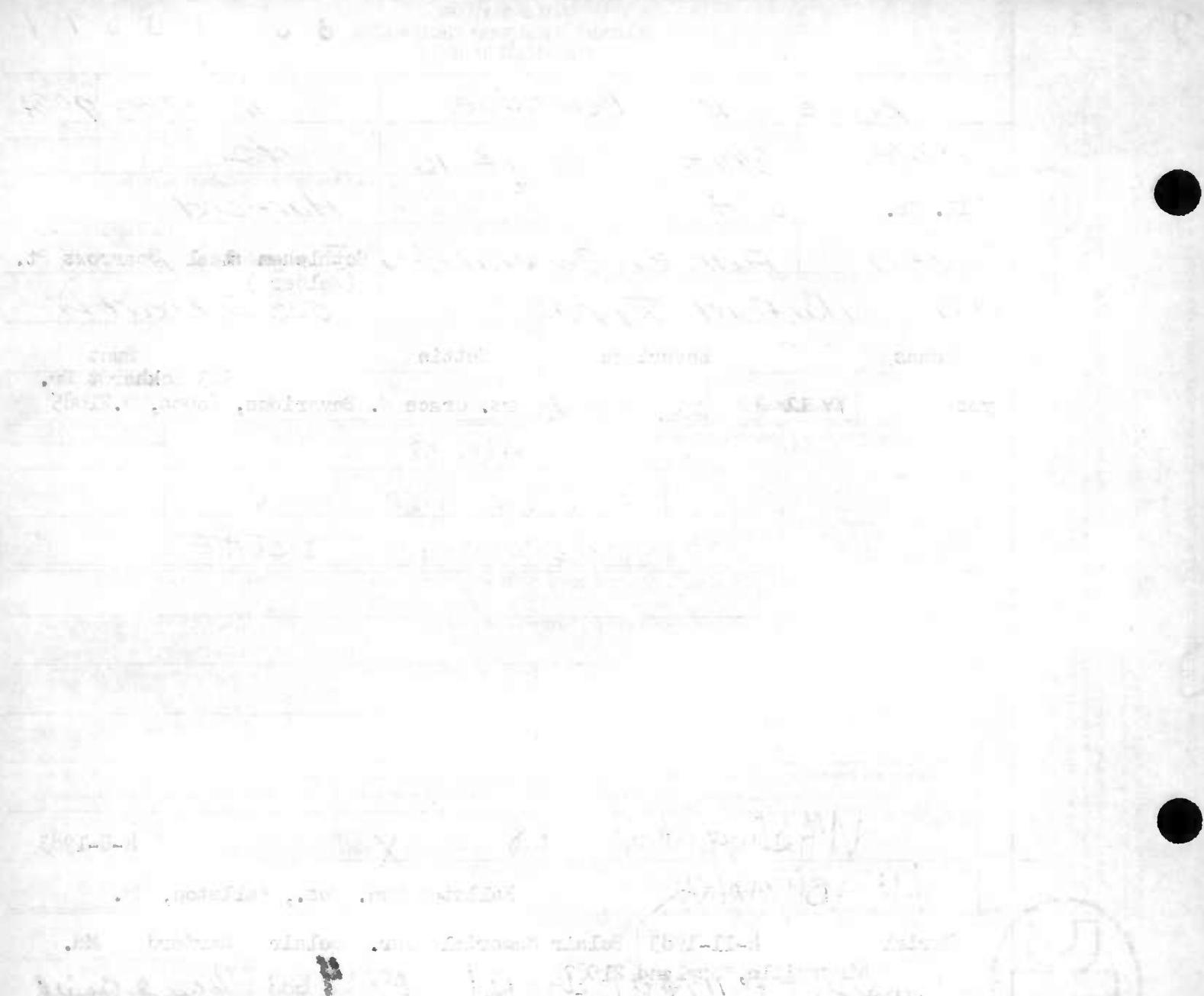


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 6 7 7		
												REG. NO.		
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Bruce B Beveridge						4 8 83			905A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		White		10 17 10			72 yrs							
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Phila. Pa.		USA					Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Fallston		Fallston General Hospt.										Bethlehem Steel Sparrows Pt. (Welder)		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY		
Md		Harford		Joppa			YES <input type="checkbox"/> NO <input type="checkbox"/>			523 Eckhardt Dr.		21025		
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
Thomas				Beveridge			Hettie					Bunt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS				
yes		1932-33		221-104046			Mrs. Grace M. Beveridge, Joppa, Md. 21085			523 Eckhardt Dr.				
4140 CARDIAC ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) VENTRICULAR FIBRILLATION														
(c) ARTERIOSCLEROTIC HEART DISEASE														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)								21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		22c. DEGREE								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED		
V.M. ABHYANKAR										MD		4-8-1983		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS												
V.M. ABHYANKAR		Fallston Gen. Hos., Fallston, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE		
Burial		4-11-1983		Belair Memorial Gar.			Belair			Harford		Md.		
24. FUNERAL DIRECTOR NAME		Kingsville Maryland 21087		E. F. Lassah P.O. Box 7750 Belair Rd			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
BP							APR 19 1983			John G. Conroy				
DHMH - 16 50M 4/82 (VRA 15, 4)														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

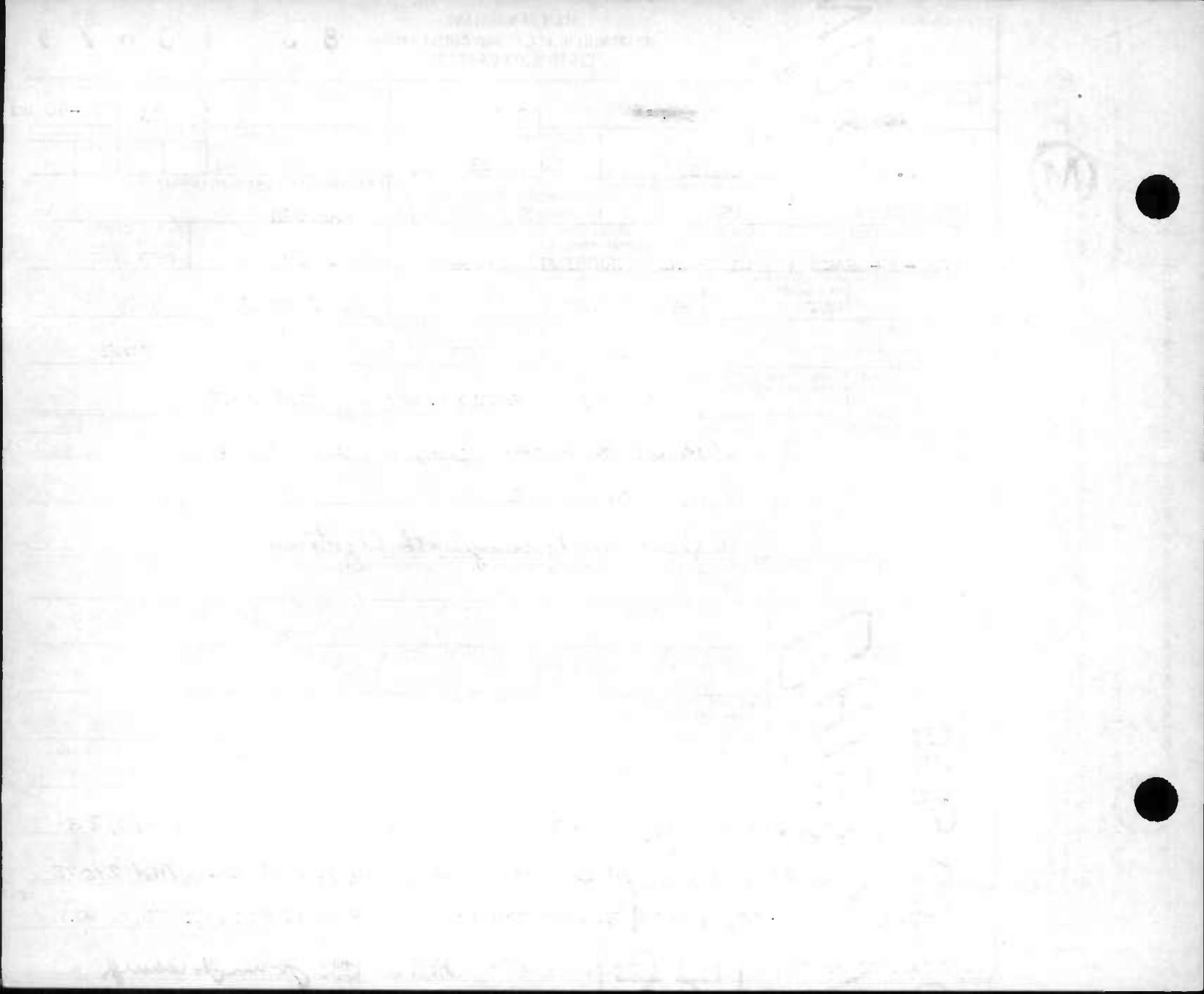
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	1	0	6	7	8
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Lloyd					Bloxham	4-1-83						7:35 AM						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
Male			White			MONTH 10 DAY 20 YEAR 1906			76			IF UNDER 24 HRS						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Baltimore			U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Harford									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Fallston			Fallston General Hosp.			Retired Engineer			State Rds. Dept.			21050						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Md.			Harford			Forest Hill						1609 Ross Rd. Forest Hill, Md.						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
Gordon					Bloxham	Annetta					Nice							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			1609 Ross Rd.						
NO			218-05-7757			Mrs. Helen J. Bloxham, Forest Hill, Md. 21050												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b), (c)																		
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3/14/83 to 4/1/83, that (I) (we) last saw the deceased alive on 3/13/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												21g. DATE SIGNED 4/1/83						
22b. SIGNATURE Linda Freil						DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 125 N Main St															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4-4-1983			23c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gar.			23d. LOCATION CITY OR TOWN Belair			COUNTY Harford						
24. FUNERAL DIRECTOR NAME			E.F. Lassam Funeral Home ADDRESS Kingsville, Md. 21087			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE 4/5/83									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	1	0	6	7	9			
										REG. NO. 4 2 83									
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
			LULA LOUISE BODDY						10 23 94				4	2	83	11-40 AM			
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
F.			BLACK			MONTH DAY YEAR			88			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
SOUTH CAROLINA			USA						HARFORD										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
HAVER-DE-GRACE			CITIZENS NURSING HOME			RETIRED COOK			RESTAURANT										
13a. STATE MD			13b. COUNTY HARFORD		13c. CITY OR TOWN HAVER DE GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 408 OLD BAY LANE		21078								
14. FATHER'S NAME FIRST LUTHER			MIDDLE THOMAS			15. MOTHER'S MAIDEN NAME FIRST MARY			MIDDLE LAST BROOKS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT FRANCIS M. WALDON			ADDRESS SAME AS #13e										
NO			217 03 4442 A																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes mellitus</i>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal Insufficiency with Azotemia</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (P) NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED <small>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>George J. Stansbury, M.D.</i>										DEGREE		22c. DATE SIGNED 4/2/83							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>George J. Stansbury, M.D.</i>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE APRIL 5, 1983		23c. NAME OF CEMETERY OR CREMATORIUM ST. JAMES CEMETERY		23d. LOCATION CITY OR TOWN HAVER DE GRACE, HARFORD,		COUNTY		STATE MD.	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME, PA, HAVER DE GRACE, MD. 21078										25a. DATE REC'D. BY REGISTRAR APR 6 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Lewis</i>							
BP _____																			
DHMH - 16 50M 4/B2 (VRA 15, 4)																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event. The medical examiner may file the original certificate in the office of the medical examiner.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may file the original certificate in the office of the medical examiner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8310680		
											REG. NO.			
1. FOR STATE REGISTRAR	FIRST			MIDDLE		LAST		2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR
	<i>Robert</i>			<i>J.</i>		<i>Bonsall</i>		<i>April 5 1983</i>						<i>4:48 P.M.</i>
2. SEX	3. RACE			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 MRS.	
Male	White			White		MONTH DAY YEAR <i>JANUARY 26, 1907</i>		76			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8.		9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				11b. KIND OF BUSINESS OR INDUSTRY	
Pennsylvania	USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Harford</i>			Maintenance - Mushroom Trans. Co.				MD.	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)													
<i>Harve de Grace</i>	<i>Harford Memorial Hospital</i>													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Maryland	Harford	Aberdeen		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Swan Road				21001			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
Frank	-		Bonsall	Elizabeth			-		Barber					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No	173-07-0951			Joanne Cox, 841 Taylor St. Kennett Square, Pa.			19348							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN UNDERLYING CAUSES		
<i>Cardiac Arrest - Asystole sudden</i>												<i>4292</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												<i>Cardiac Decompensation 2 weeks</i>		
(b)												<i>A. S. C. L. D. Classified. ? years</i>		
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
<i>C.O.P.D., ischemic ulcer on left leg.</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. DATE			22c. DEGREE			22d. DATE SIGNED						
		<i>4/5 3/28 1983</i>			<i>Edward C. Loo, M.D.</i>			<i>4/5 83</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			<i>Edward C. Loo, M.D. Harve de Grace, Md. 21078</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Burial		4-8-83			Union Hill Cemetery			Kennett Square, Penna.			19348			
24. FUNERAL DIRECTOR <i>Edward E. Hicks</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. SIGNATURE						
		<i>HICKS HOME FOR FUNERALS, ELKTON, MD. 21921</i>			APR 11 1983			<i>John J. Loo</i>						

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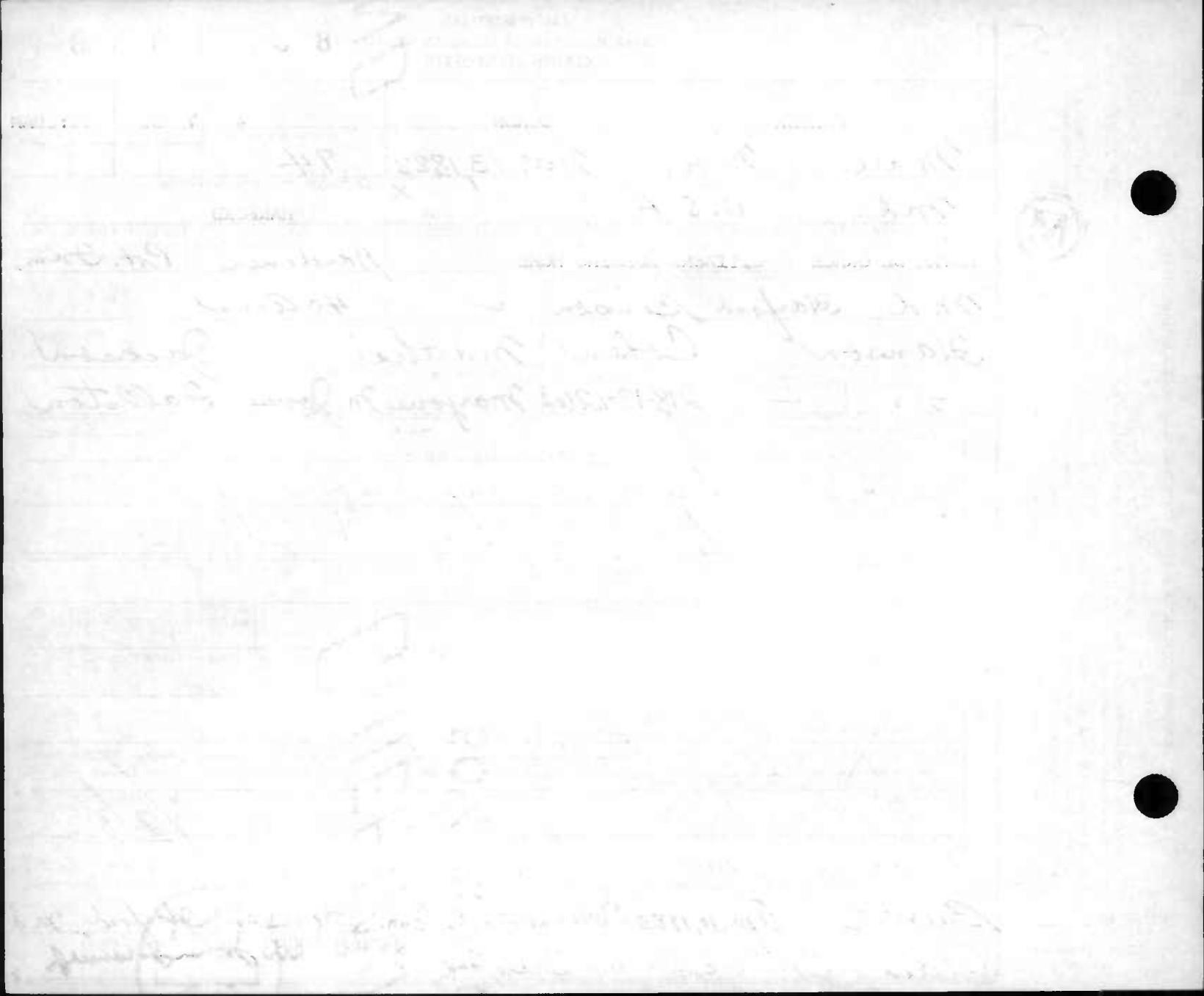
021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, it should be deposited for use at the funeral home's permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	1	0	6	8	1	
										REG. NO.							
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
		WALTER COHEN						Nov. 13, 1888				4	7	83	10:20 AM		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		Negro			Month Day Year Nov. 13, 1888			94			MONTHS	YEARS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Md.		U. S. A.						HARFORD MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
HARVE DE GRACE		CITIZENS NURSING HOME			Gardener			Port. Fam.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Md		Harford		Benson					40 Ave 21018								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Hanson				Cohen	FIRST	MIDDLE	LAST	218-18-1261			Marjorie M. Jones, Fallston						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
no		-															
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF 4110 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last:			DUE TO, OR AS A CONSEQUENCE OF acute coronary insufficiency												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)		DUE TO, OR AS A CONSEQUENCE OF other subacute abdominal pain															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/1/3 19 79 to 4/7/4 19 83, that (I) (we) last saw the deceased alive on 9/15/3 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.																	
22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/>			22e. MEDICAL DIRECTOR <input type="checkbox"/>			22f. STAFF PHYSICIAN <input type="checkbox"/>			22g. DATE SIGNED			
22g. PHYSICIAN'S NAME (TYPE OR PRINT)		22h. ADDRESS															
H. L. COHEN		319 So. Benson Ave Home of Benson 412 21028															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ESTATE			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE			
Burial		Apr. 10, 1983			Catawba U. Cem.			Benson Harford Md									
24. FUNERAL DIRECTOR		25a. DATE ISSUED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
H. L. COHEN																	
BP _____																	
DHMH - 16 50M 4/82 (VRA 15, 4)																	



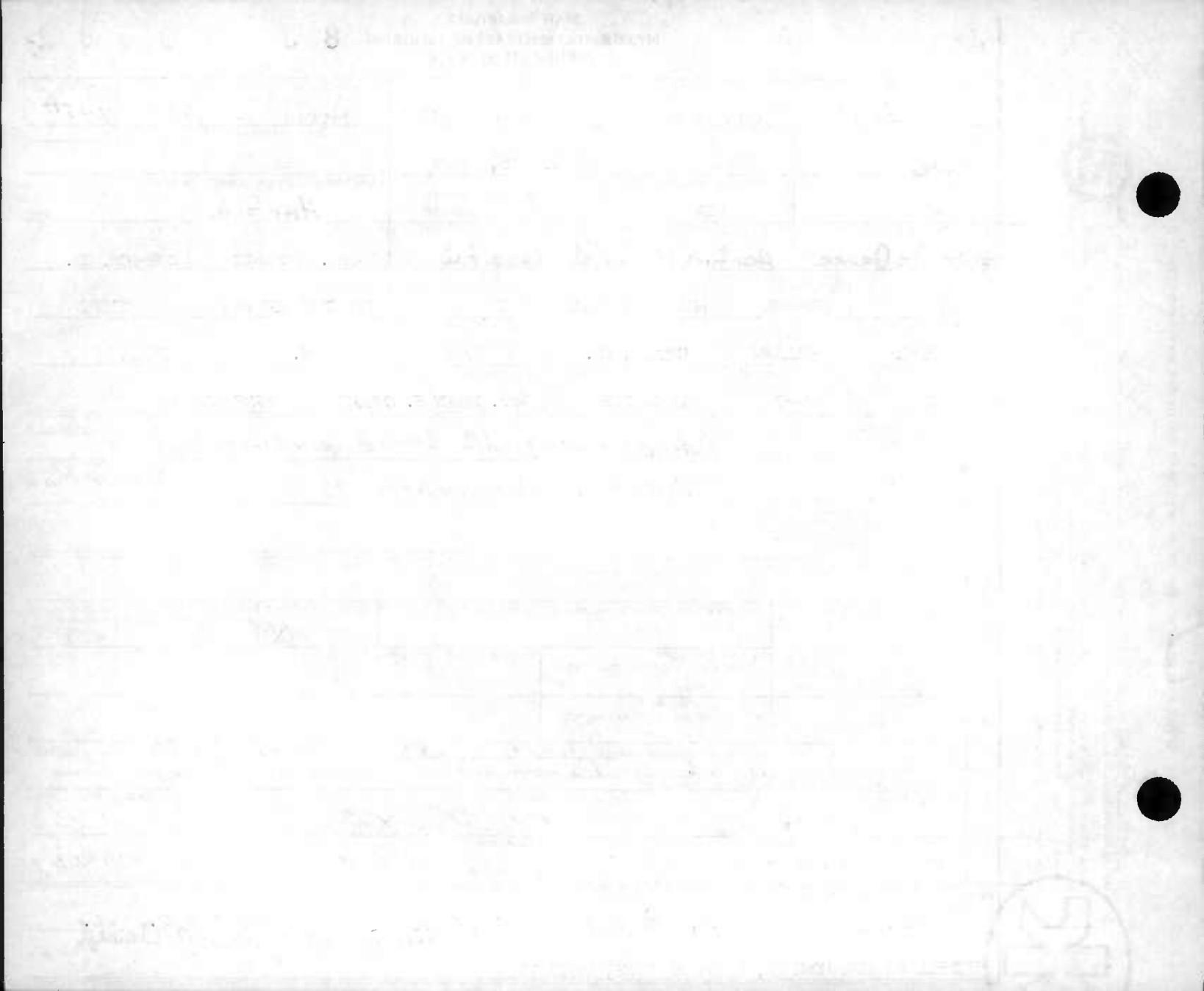
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be notified before

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 6 8 2								
										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Earl William Cullum, Jr.								April 27, 1983						7:45A M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS			
Male			WHITE			Month Day Year APRIL 25, 1942			41 YRS			MONTHS DAYS			HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
MO			USA						Harford									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Havre de Grace			Harford Memorial Hospital						MAINT. MECHANIC			CHEMICAL CO.						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
MD			HARFORD		HAVRE DE GRACE					558 CONGRESS AVE			21078					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
			EARL	WILLIAM	CULLUM, SR.				MARY	E.	SUPIK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
YES			61-63			220 34 7150			Mrs. NANCY E. CULLUM			SAME AS #13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Adeno CA Lung w/R Brain & Spinal Cord metastasis.								
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.										Due to, or as a consequence of (b) Aspiration pneumonia.								
										Due to, or as a consequence of (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-11-1983 to 4-27-1983, that (I) (we) last saw the deceased alive on 4-16-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>B. Parekh</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-27-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 1908 Harford Rd. Fallston MD 21047															
B. PAREKH MD.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE APRIL 30, 1983			23c. NAME OF CEMETERY OR CREMATORIAL GARDENS HARFORD MEMORIAL GARDENS			23d. LOCATION CITY OR TOWN HARFORD CO			COUNTY MD		STATE MD				
BURIAL									MAY 2 1983			DATE REC'D. BY CEMETERY REGISTRAR						
24. FUNERAL DIRECTOR NAME			ADDRESS															
MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD 21078																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 in marked or Item 18 shows any injury, or other traumatic event, the medical certification must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	1	0	6	8	3					
												REG. NO.											
1 - STATE REGISTRAR																							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR		
John Wilson Cully SR												April 23 83			2 PM								
1. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
Male			White			Month Day Year			75			YRS.			MONTHS DAYS			HOURS MIN.					
Aug. 29 1907						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>																	
7b. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			HARFORD											
Maryland			U.S.A.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
HAVER & GRACE HARFORD MEMORIAL HOSP			Plumber																				
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NC			13e. STREET ADDRESS			ADDRESS											
Maryland			Cecil Perryville			YES <input checked="" type="checkbox"/>			1508 Frenchtown Rd.			21903											
14. FATHER'S NAME FIRST			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST											
Milton			Cully			Carrie						Beck											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS														
No			217-03-1030			Margaret E. Cully			1508 Frenchtown Rd.			Perryville, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
(b) Due to, or as a consequence of Ischemic + Congestive																							
(c) Due to, or as a consequence of Cardiomyopathy																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 4-23 1983, to 4-23 1983, that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED JN/83											
22b. SIGNATURE Dante Monakil												DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22c. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL Hornbeam Cr., Md 21078												22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE								
Burial			Apr. 27, 1983			St. Mark's Cemetery			Perryville			Cecil			Maryland								
24. FINANCIAL DIRECTOR Lee A. Patterson & Son			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE John J. Canfield																	
Lee A. Patterson & Son, Perryville, Maryland																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 6 8 4					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
JOHN JACKSON CUMMINGS SR.						April 19, 1983						3:55 p.m.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		Black		MONTH	DAY	YEAR	61 yrs.			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.										
MD		USA															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Perry Point		VA Medical Center Perry Point, MD															
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
				Baltimore						310 Mt. Holly St. 21229							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS										
Yes		217-16-1341		Lillabelle Butler			2403 Roslyn Ave.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Pulmonary edema, bilateral													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of right lung w/widespread metastasis																	
{ DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (X) this hospital attended the deceased from Mar 29, 1983, to Apr 19, 1983, that (X) (we) lost saw the deceased alive on Apr 19, 1983, and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (could) view the body after death.													22b. SIGNATURE <i>Mahmut N. Atay</i>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) MAHMUT N. ATAY, M.D.													DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED 4-20-83
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial													23b. DATE 4/25/83	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cem.	23d. LOCATION CITY OR TOWN Baltimore	COUNTY	STATE MD.
24. FUNERAL DIRECTOR NAME March Funeral Home, Baltimore, Md.													25d. DATE REC'D. BY REGISTRAR APR 21 1983	25e. REGISTRAR'S SIGNATURE <i>James Gandy</i>			
DHMH - 16 50M 4/B2 (VRA 15, 4)																	

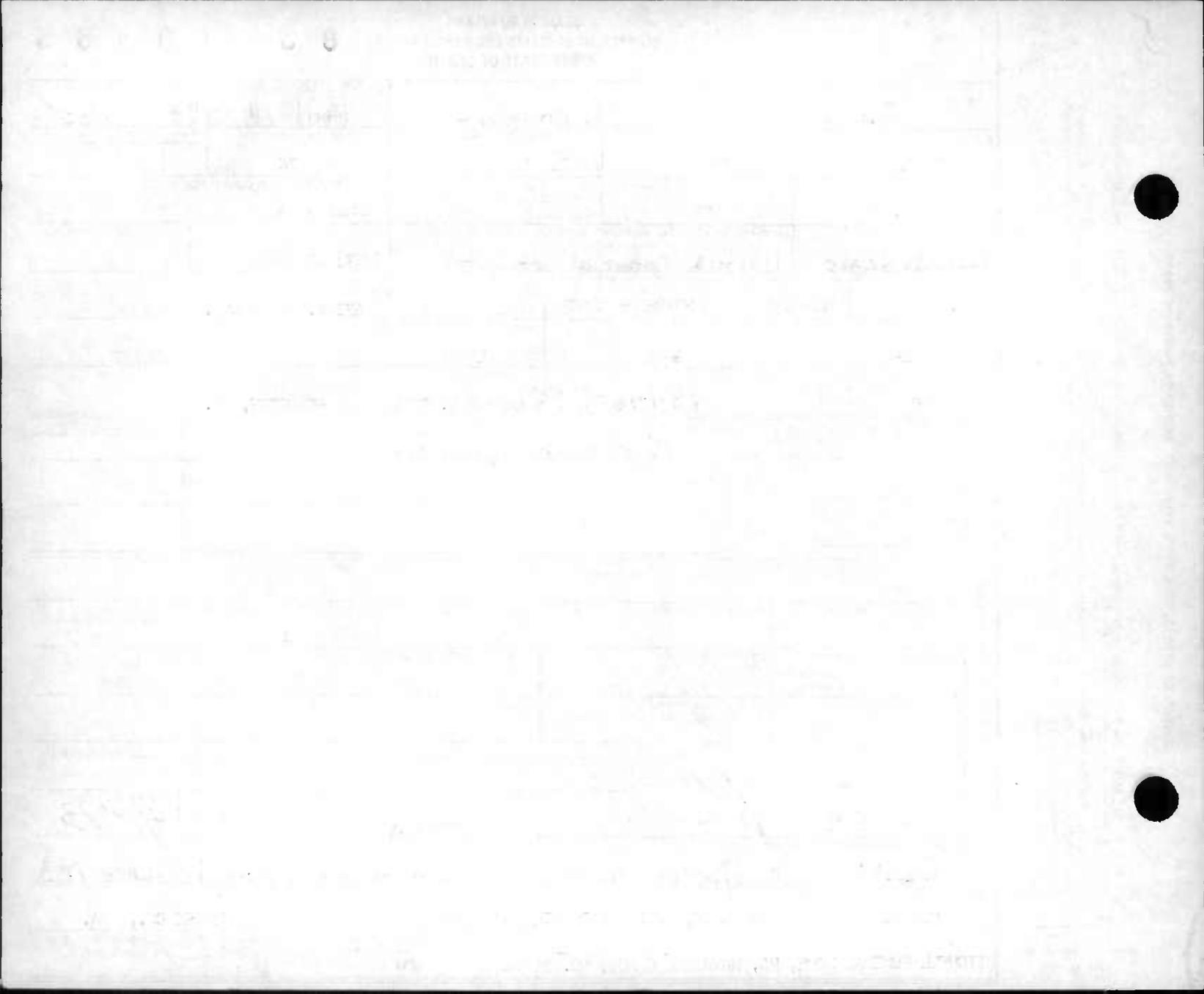
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
SAVILLA					Cummings	April 14, 1983						6:05 PM						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE			WHITE			MONTH APRIL DAY 18, 1906 YEAR			76 YRS.			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
PA.			USA						Harford									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) WAITRESS			12b. KIND OF BUSINESS OR INDUSTRY									
Havre de Grace			Harford Memorial Hospital															
13a. STATE MD.			13b. COUNTY HARFORD			13c. CITY OR TOWN HAVRE DE GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 421 S. UNION AVE.			21078			
14. FATHER'S NAME FIRST JOHN MIDDLE BUBB LAST			15. MOTHER'S MAIDEN NAME FIRST LYDIA MIDDLE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO 184-16-7178			17. INFORMANT LESTER W. COBLE			ADDRESS ABINGTON, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4299			DOUE TO, OR AS A CONSEQUENCE OF (b)			DOUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/14/83									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
GUNTHER D. HIRSCH M.D.			131 S Union Ave Havre de Grace, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN									
BURIAL			APRIL 16, 1983			ZION HILL CEMETERY			CITY OR TOWN									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
MITCHELL FUNERAL HOME, PA, HAVRE DE GRACE, MD. 21078						APR 18 1983			John J. Lough									



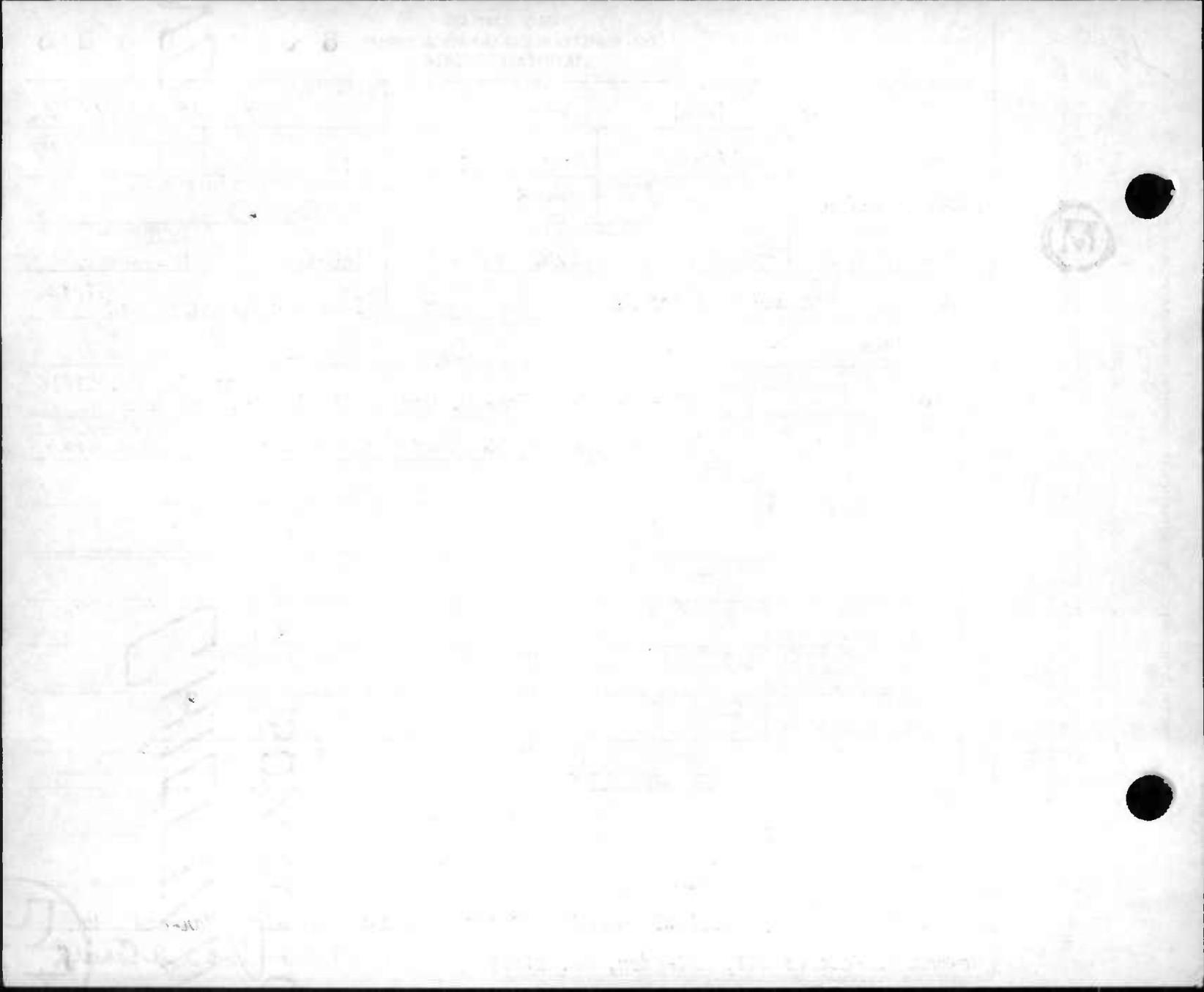
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be sent with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	1	0	6	8	6
												REG. NO.						
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>RAY</i>	MIDDLE <i>(mn)</i>	LAST <i>DAY</i>	2a. DATE OF DEATH			MONTH <i>4</i>	DAY <i>25</i>	YEAR <i>83</i>	2b. HOUR <i>955 AM</i>					
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male	White			MONTH <i>March</i> DAY <i>28</i> YEAR <i>1905</i>			78			MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN <i>SOUTH</i> <i>North Carolina</i>)	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>			MD.								
10 CITY OR TOWN OF DEATH <i>FALLSTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FALLSTON GENERAL Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>US-govt. Ret.</i>											
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Bel Air</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <i>2220 Old Emmorton Road</i>			21014									
14. FATHER'S NAME FIRST <i>John</i>	MIDDLE <i>--</i>	LAST <i>Day</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>			MIDDLE <i>--</i>	LAST <i>Day</i>	ADDRESS <i>Bel Air, Md. 21014</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	16b. SOCIAL SECURITY NO. <i>212-26-3914</i>			17. INFORMANT <i>John W. Day, 2220 Old Emmorton Road</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiomyopathy of Salent Failure.</i>																		
4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		
DUE TO, OR AS A CONSEQUENCE OF (b) _____																		
DUE TO, OR AS A CONSEQUENCE OF (c) _____																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <i>3-24</i> , 19 <i>83</i> , to <i>4-25</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>4-25</i> , 19 <i>83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>BPS</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. D. Parekh</i>			22e. ADDRESS <i>1708 Harford Rd. MD. 21047</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Apr. 28, 1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>BelAir Memorial Gardens, Bel Air</i>			23d. LOCATION CITY OR TOWN <i>Harford</i>			COUNTY <i>Md.</i>	STATE					
24 FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md. 21009</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>APR 27 1983</i>			REGISTRAR'S SIGNATURE <i>John J. Conroy</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

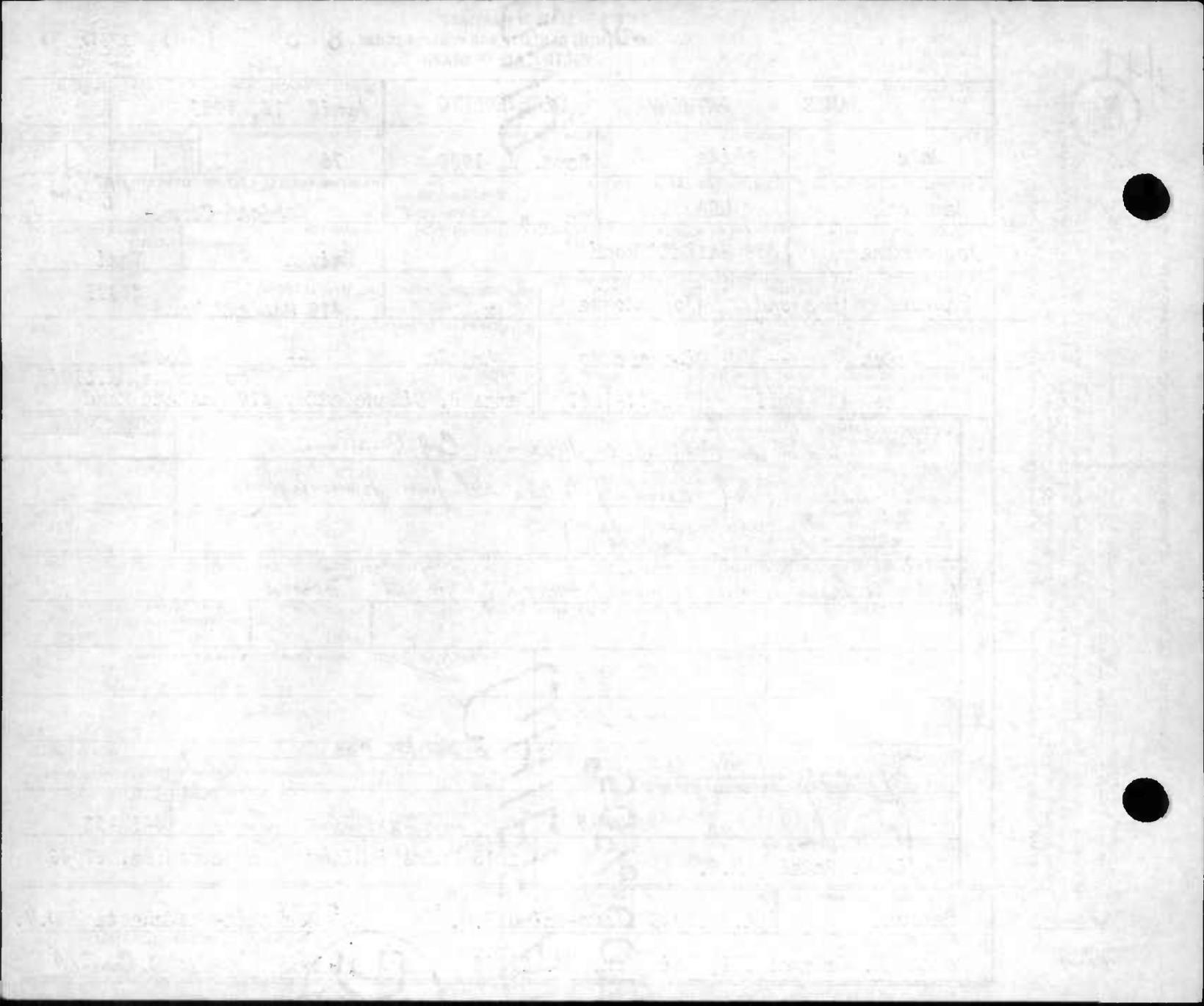
1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 3 1 0 6 8 1									
									REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
<i>Belia Elizabeth Deane</i>												<i>April 6, 1983</i>					<i>5:00 AM</i>	
3. SEX <i>Female</i>			4. RACE <i>WHITE</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>June 15, 1915</i>			6. AGE (IN YEARS, LAST BIRTHDAY) YRS. <i>67</i>			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>MD.</i>				
10. CITY OR TOWN OF DEATH <i>HARFORD</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD Memorial Hospital</i>			12. CITY OR TOWN <i>Aberdeen</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>112 Graceford Drive Aberdeen</i>		21001				
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>			13c. CITY OR TOWN <i>Aberdeen</i>			13e. STREET ADDRESS <i>McNamara</i>			ADDRESS <i>Virginia 23227</i>						
14. FATHER'S NAME FIRST <i>Heber</i>			MIDDLE <i>Hobson</i>			LAST			15. MOTHER'S MAIDEN NAME FIRST <i>Sadie</i>			ADDRESS <i>Frances Parsley 5801 Bonnesh Rd. Richmond</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>231-30-7131</i>			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN INJURY AND DEATH									
18. CAUSE OF DEATH: Enter only one cause per line for 18a, 18b, and 18c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Disseminated intravascular Coagulopathy</i>			18b. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia, Tuberculosis</i>			18c. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute myocardial infarction</i>												
19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>5-2</i> , 19 <i>83</i> , to <i>4-6</i> , 19 <i>83</i> , that (II) (we) lost saw the deceased alive on <i>4-6</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) did not view the body after death.																		
22b. SIGNATURE <i>Brian T. Yeo</i>			22c. DEGREE <i>M.D.</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>April 6, 1983</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BRIAN T. Yeo</i>			22e. ADDRESS <i>801 S. Union Ave, Harford Grace MD.</i>															
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal/Burial</i>			23b. DATE <i>9 April 1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Oakwood Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Richmond</i>		COUNTY		STATE <i>Virginia</i>					
24. FUNERAL DIRECTOR NAME <i>Tarring Funeral Home, P.A. Aberdeen, MD 21001</i>			25a. ADDRESS <i>339</i>			25b. DATE REC'D. BY REGISTRAR <i>APR 11 1983</i>			25c. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please attach it to the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 6 8 8
										REG. NO.
1 - FOR STATE REGISTRAR	FIRST JAMES	MIDDLE ANTHONY	LAST DiBENEDETTO	2a. DATE OF DEATH	MONTH April	DAY 18	YEAR 1983	2b. HOUR M		
I. DECEASED NAME (TYPE OR PRINT)	3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Sept. 2, 1906 DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 4	HOURS MIN. 50 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.							
10 CITY OR TOWN OF DEATH Joppatowne	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 419 Haslett Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver	12b. KIND OF BUSINESS OR INDUSTRY Taxi							
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Joppatowne	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21085 419 Haslett Road						
14. FATHER'S NAME FIRST Peter	MIDDLE --	LAST DiBenedetto	15. MOTHER'S MAIDEN NAME FIRST Angela	MIDDLE --	LAST Costa					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. WWII	17. INFORMANT James P. DiBenedetto, 419 Haslett Road	ADDRESS Joppatowne, Md. 21085							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC Squamous Cell Carcinoma</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>according to info obt from Johns Hopkins</i> (c) <i>Leukemia</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arthritis Secondary to liver & kidney. Anemia. Adult onset Diabetes</i>										
20. MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
		22a. I certify that (I) (this hospital) attended the deceased from <i>APR 18 1983</i> to <i>19</i> , that (I) (we) lost saw the deceased alive on <i>Nov. 16 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.	22b. SIGNATURE <i>Rafiq K. Patel</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4-1-83				
		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafiq K. Patel, M.D.	22e. ADDRESS 2013 Pulaski Highway, Edgewood, Md. 21040							
		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE Apr. 18, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Sisto-Paino F.H.	23d. LOCATION CITY OR TOWN New Rochelle-Westchester, N.Y.	COUNTY	STATE			
		24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009	ADDRESS	25a. DATE REC'D. BY REGISTRAR APR 19 1983	25b. REGISTRAR'S SIGNATURE <i>John G. Cawieh</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The retained by the hospital or attending physician.

N: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by a physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 3 1 0 6 8 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Elizabeth Anne Drover</i>						4-18-83					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		MONDAY 3-4-1914		69		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		M.D.			
Indiana		U.S.A.				<i>Harford County</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY			
Belair		<i>717 Country Village Dr.</i>				<i>Mid West Sales & Service</i>		<i>Retire</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						21014					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Harford		Belair		YES <input checked="" type="checkbox"/>		<i>717 Country Village Dr. - 2 D</i>			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
FIRST			MIDDLE			LAST			FIRST		
<i>Alexis Rupel</i>									<i>Mary E. Coquillard</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					
NO						<i>312-03-2149</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:						17. INFORMANT					
IMMEDIATE CAUSE (a) <i>exsanguination</i>						ADDRESSEE <i>Mrs. Carol Anne Gray Belair, Md. 21014</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>decortic lung cancer</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						<i>2 months</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (We) attended the deceased from <i>3/2</i> 19 <i>83</i> , to <i>4/18</i> 19 <i>83</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated now the deceased gave up above and did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/19/83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
<i>Albert L. Blumberg MD</i>		<i>6701 N. Charles</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		4-23-83		River View Cemetery		South Bend, Indiana					
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd. - 21206</i>						25a. DATE REC'D. BY REGISTRAR ADDRESS <i>APR 20 1983</i>					
						25b. REGISTRAR'S SIGNATURE <i>John C. Miller</i>					

- 1 -

REVIEW AND STUDY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-troune permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	1	0	6	9	0	
										REG. NO.							
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2d. DATE OF DEATH		MONTH	DAY	YEAR	2d. HOUR	
		<i>Ada Lorraine Dubree</i>									<i>April 20, 1983</i>		<i>12:26</i>	<i>PM</i>	<i>12:26</i>		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE		WHITE			MAY 13, 1924			58 YRS.			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
VA.		USA						<i>Hartford</i>									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
<i>Havre de Grace</i>		<i>Hartford Memorial Hosp.</i>						<i>HOUSE WIFE</i>									
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 206 WILSON STREET			21078					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
JEFFERSON		—		DAVIS		VEROIE			—			HENDERSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
NO		217 26 8254			SANDRA L. HILOITCH 77 SMITH AVE., ABEROEN, MD. 21001												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF, Coronary Artery Disease ARTERY DISEASE MATERIAL SCLEROsis																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-19 19 63 to 4-20 19 83, that (I) (we) last saw the deceased alive on 4-20 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								<i>4/20/83</i>							
<i>Dante Monakil</i>		<i>Havre de Grace, Md 21078</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE					
BURIAL		APRIL 23, 1983			ROCK RUN CEMETERY			—		HARFORD CO., MO.							
24. FUNERAL DIRECTOR NAME		ADDRESS								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD		21078								<i>APR 25 1983</i>		<i>John J. Carroll</i>					

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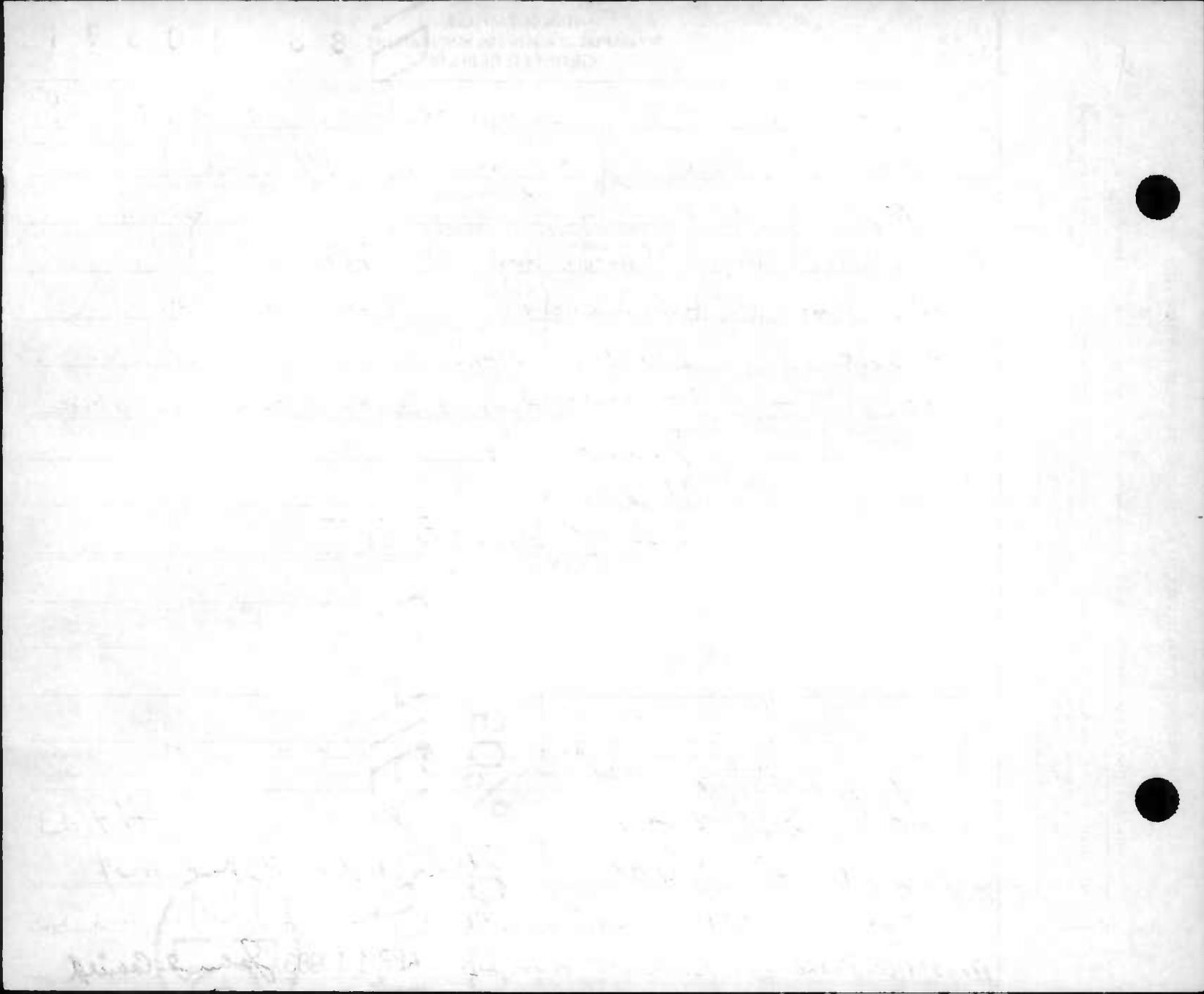
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	4 4 1983				10 15 PM			
William A. Durbin SR.														
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Black		5 28 05			77			YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Hartford MD.				
Md.		USA												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Havre de Grace		Hartford Memorial Hosp		Retired										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		230 Superior St. 21078			
Md.		Hartford		Havre de Grace			YES <input type="checkbox"/>		230 Superior					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Frank				Durbin	Mary					Chambers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS							
NO		214-20-6733		Anna M. Durbin			Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) <i>Alzheimers</i>														
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer of Prostate</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-4 1983 to 4-4 1983, that (I) (we) lost the deceased alive on 4-4 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. In (we) (we) did not view the body after death.														
22b. SIGNATURE				DEGREE			ATTENDING MEDICAL PHYSICIAN		STAFF DIRECTOR		PHYSICIAN			
<i>John D. Yun</i>														
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. ADDRESS			22f. DATE SIGNED							
John D. Yun				Havre de Grace, MD			4/9/83							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		4/9/83		St. James Cemetery			Havre de Grace		Harford		MD.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR/REGISTRAR'S SIGNATURE										
Arnold W. BEARD 353 Fountainst. HDG. MD				APR 11 1983			<i>John J. Conigli</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked off, Item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 6 9 2				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Ro SA (mn)					Edwards	4 9 83						8:30 AM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female			White			Aug. 14, 1899			83			MONTHS DAYS		IF UNDER 24 HRS		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Virginia			USA						Harford							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Fallston			FALLSTON Gen Hospt			Housewife										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21154	
Maryland			Harford			Street						3305 Dublin Manor Road				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
			L.	C.	Barker				Martha	--	Blevins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
no			215-42-1826			Donald G. Edwards, 3305 Dublin Manor Road			Street, Md. 21154							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
(b) <u>cardiac arrest</u>																
{ DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u>																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 18 FF, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			19 10, to 419 19 83													
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									4/18/83				
DANTE N. MONAKIL			622 S. Union Ave, Harford, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			April 12, 1983			Oak Grove Baptist Cemetery, BelAir			Harford			Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Howard K. McComas III, Abingdon, Md. 21009						APR 12 1983			John J. Comer							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 3 1 0 6 9 3			
						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST				
<i>GEORGE WILLIAM EVANS</i>									
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		20. DATE OF DEATH MONTH DAY YEAR <i>APRIL 18, 1983</i>			
<i>MALE</i>			<i>WHITE</i>	<i>JAN. 29, 1910</i>		21. HOUR <i>6 26 AM</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>TENNA.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD Co.</i>			
10. CITY OR TOWN OF DEATH <i>FALLSTON</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FALLSTON GENERAL HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE FOR WORK FOR MOST OF WORKING LIFE) <i>FARMER</i>			
13a. STATE <i>MD</i>			13b. COUNTY <i>HARFORD</i>	13c. CITY OR TOWN <i>BEL AIR</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>419 CLEAR STRINE ROAD</i>			
14. FATHER'S NAME FIRST <i>HUGH</i>			MIDDLE <i>A.</i>	LAST <i>EVANS</i>	15. MOTHER'S MAIDEN NAME FIRST <i>MARY</i>	MIDDLE <i>GOOD</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>210-30-0146</i>		17. INFORMANT <i>NANCY E. DOWDY, BEL AIR, MD.</i>	ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4120</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CARDIAC ARREST</i>									
(c) <i>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>HISTORY OF MYOCARDIAL INFARCTION / HISTORY OF CARDIAC ARRREST</i>									
19a. DATE OF OPERATION <i>APRIL 13, 1983</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>LEFT INGUINAL HERNIA</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>H. L. Williams, MD</i>						DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>APR 16 1983</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. L. Williams, MD</i>			22e. ADDRESS <i>FALSTON GENL HOSP, FALLSTON, MD</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>4-21-83</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>SLATE RIDGE</i>		23d. LOCATION CITY OR TOWN <i>DELTA</i>	COUNTY <i>YORK</i>	STATE <i>PA</i>	
24. FUNERAL DIRECTOR NAME <i>John H. Harkins, DELTA, PA</i>			25a. DATE REC'D. BY REGISTRAR <i>APR 21 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>			

M

CHARTER
BOAT RENTALS

August 2000 - 1000 hours - 1000 hours

2000 hours - 2000 hours - 2000 hours

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR STATE 5-31-83 cn REGISTRAR Item #17, 14, 15 Film G580 6/21/83 rc				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 6 9 4					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				REG. NO.					
FIRST		MIDDLE		LAST									
Vernon Burgette Garvin				4-2-83				6:30 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Male		Cauc.		10-9-1895		87							
7e. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford		10. USUAL OCCUPATION Auto Mech. Ret. Automobile		11. KIND OF BUSINESS OR INDUSTRY Automobile			
Rising Sun, Md.		U.S.A.											
10. CITY OR TOWN OF DEATH Harve de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Harford Memorial Hosp.		12. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS 444 Lewis Lane		14. FATHER'S NAME Harvey K. Garvin		15. MOTHER'S MAIDEN NAME Mary V. Zwing			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES OR UNKNOWN XXXXXX		16b. SOCIAL SECURITY NO. 216-01-7832		17. INFORMANT Mirrored		18. ADDRESS 1447 Clayton St.		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8880 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.U.D. Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		20. APPROXIMATE PERTINENCY BETWEEN ONSET AND DEATH about 2 weeks (?)			
21a. DATE OF OPERATION 2/25/83		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of right hip		20a. AUTOPSY? reduction		20b. IF YES, WERE FINDINGS USED in determining cause of death YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR (P.M.) 2-22 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY, PART I, PART II) Fell in his daughter's yard	
22d. SIGNATURE Edward C. Lee, M.D.		22e. DEGREE		22f. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED 4/3/83		23a. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. Lee, M.D.		23b. ADDRESS Harve de Grace, Md. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-5-83		23c. NAME OF CEMETERY OR CREMATORIAL Brookview Cem.		23d. LOCATION CITY OR TOWN Rising Sun		23e. COUNTY Cecil		23f. STATE Md.			
24. FUNERAL DIRECTOR NAME Richard L. Goodie Rising Sun, Md.		25a. DATE REC'D. BY REGISTRAR APR 7 1983		25b. REGISTRAR'S SIGNATURE John J. Conwell									

for us at first we find additional data. This may well
be necessary to make comparisons and draw conclusions
based upon information.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit's permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 6 9 5	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Louise Klair Gorsuch						April 11 1983			3:09 P	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
FEMALE		WHITE		FEB. 16, 1903			80 YRS.						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford			MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET.) TEACHER			12b. KIND OF BUSINESS OR INDUSTRY EDUCATION						
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 803 ONTARIO STREET		21078		
14. FATHER'S NAME FIRST LOUIS		MIDDLE H.		LAST KLAIR			15. MOTHER'S MAIDEN NAME FIRST CORA		MIDDLE BELL		LAST WERNER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-44-2251		17. INFORMANT JOYCE E. GORSUCH 104 VICTORIA CT, NORTH EAST, MD.			ADDRESS 21901						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> 4241 DOUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO GENIC SHOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ARTIC STENOSIS - CRITICAL</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes hours months.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>CORONARY ARTERY DISEASE</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/10/83</u> , to <u>4/11/83</u> , that (I) (we) last saw the deceased alive on <u>4/10/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 4/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barney A. Wohl		22e. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APRIL 14, 1983			23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY			23d. LOCATION CITY OR TOWN HAVRE DE GRACE, HARFORD, MD.			23e. COUNTY		STATE
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR APR 15 1983			25b. REGISTRAR'S SIGNATURE John J. Connel								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please return to the attending physician. This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If Item 21 is marked or Item 18 shows any injury, or either traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8310696	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
WALTER S GRANT				S	GRANT	APRIL 10			1983		132 PM		
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.		
Male			White	Nov 23, 1901			81 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			U.S.A.						Harford				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Harford de Grace			Harford Memorial Hospital			Maintenance Supr.			Town Port Deposit				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Maryland			Cecil			Conowingo						467 Rocks Spring Rd. 21918	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Charles			S.	Grant	Elizabeth				Fuller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
no			220-14-6335			Marjorie G. Grant			Conowingo, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for part (b), and if applicable, for part (a). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))													
4100 Acute Myocardial infarction													
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY P.M.			21c. HOW INJURY OCCURRED HOUR A.M. MONTH DAY YEAR P.M. 19			22. ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19, to APRIL 10, 1983, that (I) (we) lost the deceased alive on APRIL 10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did/did not view the body after death.													
22b. SIGNATURE			DEGREE						22c. DATE SIGNED				
John D. YAN									4/10/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
John D. YAN			Harford de Grace, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY	
Burial			Apr. 13, 1983			Hopewell Cemetery			Port Deposit			Cecil Maryland	
24. FUNERAL DIRECTOR John D. Patterson & Son, Perryville						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
						APR 19 1983			John D. Carrick				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8310697			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Roland Elmer Graybeal						4-1-83						12 ⁴⁵ PM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE			WHITE			MONTH DAY YEAR			67			MONTHS DAYS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Roan Mountain TENN			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARford MD.						
10. CITY OR TOWN OF DEATH FALLston (21047)			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) fallston General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SANITOR			12b. KIND OF BUSINESS OR INDUSTRY church						
13a. STATE Maryland			13b. COUNTY Harford Co.			13c. CITY OR TOWN Bel Air (21014)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 21014 300 Sunflower Drive			
14. FATHER'S NAME FIRST JOHN MIDDLE CLINTON LAST Graybeal						15. MOTHER'S MAIDEN NAME FIRST Etta MIDDLE LAST Calhoun									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. —			17. INFORMATION (SISTER) 134-7320 ADDRESS Mrs. FRANCES N. CHILDERS / 1402 STEPNEY Road Aberdeen, Maryland 21001						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA, BASE OF TORSUE 1410 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
—			—			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (we) attended the deceased from late 1981 or early 1982 to April 1, 1983, that (II) (we) last saw the deceased alive on April 1, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.															
22b. SIGNATURE C.W. Gehris, Jr. M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED April 2, 1983						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.W. GEHRIS, JR. M.D.			22e. ADDRESS 1916 BELAIR RD, FALLSTON, MD, 21047												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 4, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Highview Memorial Gardens			23d. LOCATION CITY OR TOWN Fallston, Harford Co., Maryland 21047						
24. FUNERAL DIRECTOR Joseph William Foster Joseph William Foster			ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR APR 5 1983			25b. REGISTRAR'S SIGNATURE Selina J. Calhoun						

HISTORICAL CHRONICLES, THREE JOURNALS

60. Three historical journals

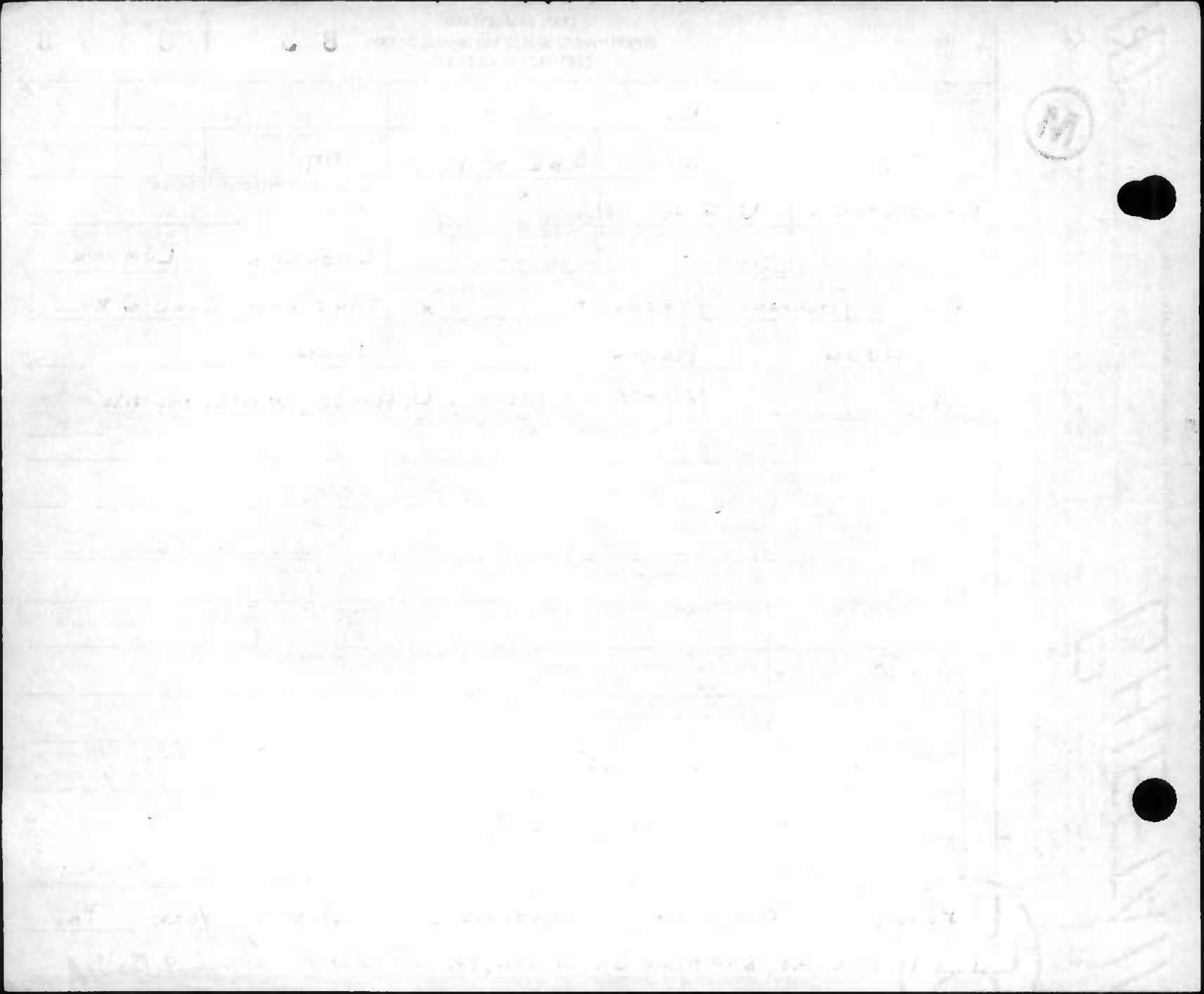
1804-1805 - 1804 - 1805

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical certification and/or the medical director's signature must be attached to this page.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8310698	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	4-20-83			10:44 A.M.				
2. SEX			RACE	3. DATE OF BIRTH MONTH DAY YEAR		4. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR # UNDER 24 HRS.				
MALE			WHITE	APR. 5, 1906		77			MONTHS DAYS HOURS MIN.				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7d. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD				
PENNSYLVANIA			U.S.A.										
10. CITY OR TOWN OF DEATH HARVE DE GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HARFORD MEMORIAL HOSPITAL			12a. USUAL OCCUPATION LABORER			12b. KIND OF BUSINESS OR INDUSTRY LUMBER				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.			13b. COUNTY HARFORD	13c. CITY OR TOWN STREET	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3740 DAVIS CORNER ROAD							
14. FATHER'S NAME HUGH			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 191-079-2394			17. INFORMANT ODESSA L. HODGE, WHITEFORD, Md.			ADDRESS				
18. CAUSE OF DEATH: Enter only one cause per line for each Part 1 and Part 2. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A. S. C.I.D. ? 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Chrome Brain Syndrome ? DUE TO, OR AS A CONSEQUENCE OF (c) due to senility.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1c, PART 1, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4-17 1983 to 4-20 1983, that (I) (we) last saw the deceased alive on 4-20 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE Edward C. Loo, MD			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/20/83				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, MD			22g. ADDRESS HARVE DE GRACE, MD										
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE APR. 22, 1983			23c. NAME OF CEMETERY OR CREMATORY SLATEVILLE			23d. LOCATION CITY OR TOWN DELTA COUNTY YORK STATE PA				
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 MAIN ST., DELTA, PA									25a. DATE REC'D. BY REGISTRAR APR 26 1983			25b. REGISTRAR'S SIGNATURE John H. Conroy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in all respects, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

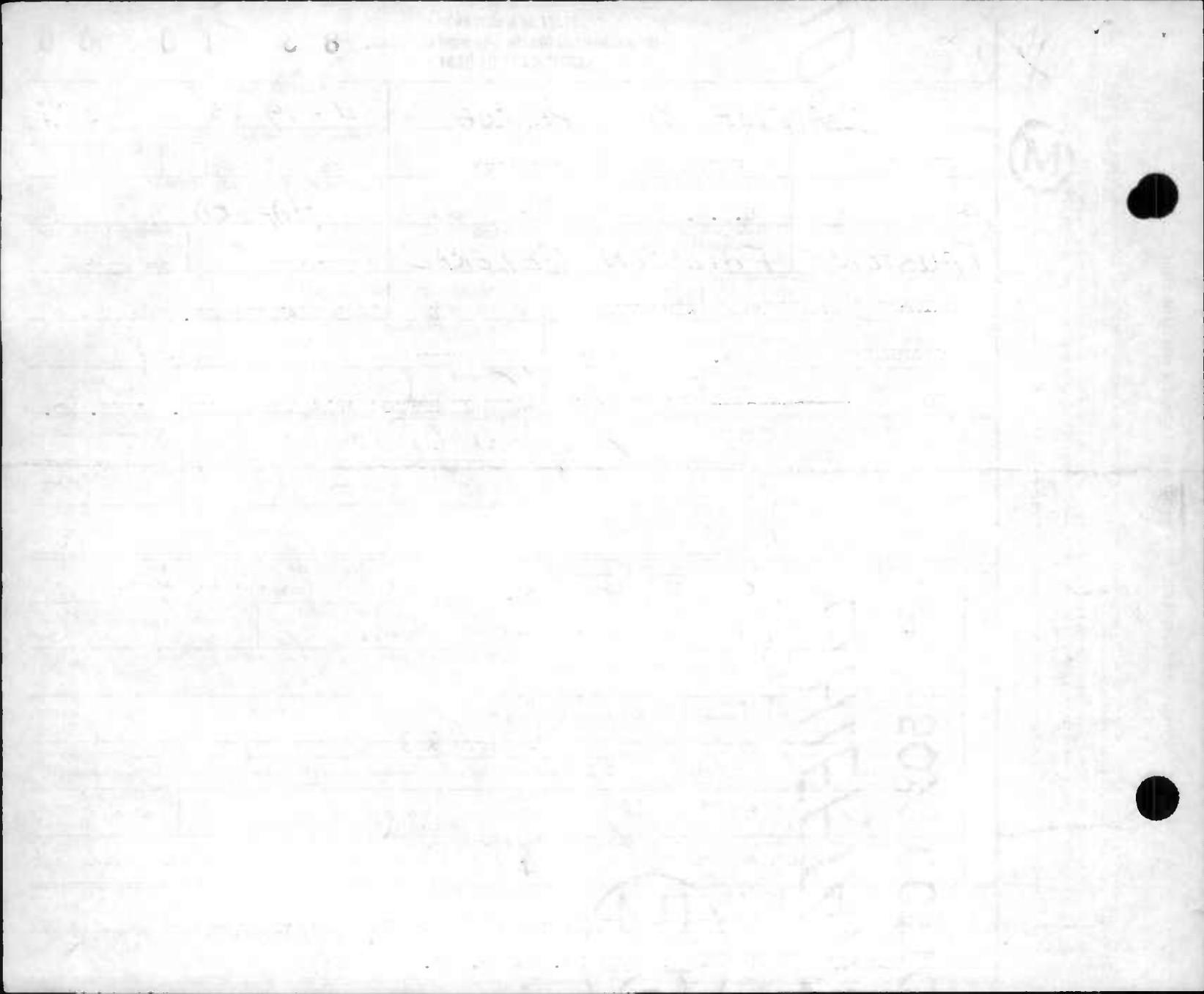
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	1	0	6	9	9
										REG. NO. 80699						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
LINDA ANDERSON					HENRY	4-8-83						11:58 M				
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				
Female			Black			2 3 1953						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Kentucky			USA						Harford							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Havre de Grace			Harford Memorial Hospital			Homemaker			Home							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Harford			Havre de Grace			YES <input checked="" type="checkbox"/>			341 Wilson Street 21078				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
Earl					Anderson	Eileen						McKinney				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			400-80-7083			David T. Henry, 341 Wilson St., Havre de Grace										
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3940 (Cause - ruler) Arrest																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (Cause - ruler) Death (Cause - ruler) Mitral Valve Replacement																
(c) 577 Mitral Valve Replacement																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
1978			Mitral Stenosis						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-2 1983 to 4-8 1983, that (I) (we) last saw the deceased alive on 4-8 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4-8-83							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS													
A. H. CALON																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			13 April 83			Asbury United Methodist Churchville Harford Md.										
24. FUNERAL DIRECTOR NAME																
ADDRESS																
Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399 APR 18 1983 John J. Calon																
25a. DATE REC'D. BY REGISTRAR'S OFFICE REGISTRAR'S SIGNATURE																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8310700	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			<u>ISABELLE M HERZOG</u>						<u>4-19-83</u>			<u>5:04 PM</u>	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE			WHITE			<u>8/28/1923</u>			59 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>CANADA</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>HAFECO</u>			MD.	
10. CITY OR TOWN OF DEATH <u>FALLSTON</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FALLSTON GENERAL</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>				
13a. STATE <u>MARYLAND</u>			13b. COUNTY <u>BALTIMORE</u>			13c. CITY OR TOWN <u>KINGSVILLE</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <u>7449 BRADSHAW RD. 21087</u>	
14. FATHER'S NAME FIRST <u>CHARLES</u>			MIDDLE <u>A.</u>			LAST <u>LOCK</u>			15. MOTHER'S MAIDEN NAME FIRST <u>FEODE</u>			MIDDLE LAST <u>BRIGGS</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>219 12 9037</u>			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>4413</u>			IMMEDIATE CAUSE (a) <u>Rupture Abdominal -</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aortic Aneurysm.</u>			DUE TO, OR AS A CONSEQUENCE OF (c)			<u>6 hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Large abdominal Aortic Aneurysm.</u>													
19a. DATE OF OPERATION <u>4/19/83</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rupture abdominal Aorta Aneurysm</u>			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2) <u>4/19/83</u> , to <u>4/19/83</u> , that (I) (we) last saw the deceased alive on <u>4/19/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u>4117</u>			CITY OR TOWN <u>4117</u>			COUNTY <u>21087</u>	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>4/19/83</u> to <u>4/19/83</u> , that (I) (we) last saw the deceased alive on <u>4/19/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>4/19/83</u>	
22b. SIGNATURE <u>M. JESADA, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. JESADA, M.D.</u>			22e. ADDRESS <u>433 Girard St. Hause de France, MD</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>4/22/1983</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>BELAIR MEMORIAL GARDENS</u>			23d. LOCATION CITY OR TOWN <u>BELAIR, MARYLAND</u>			COUNTY	STATE
24. FUNERAL DIRECTOR <u>DIPPEL FUNERAL</u>			ADDRESS <u>HOMES 7110 BELAIR RD. BALTO. MD</u>			25a. DATE REC'D. BY REGISTRAR/ST. REGISTRAR SIGNATURE <u>JAN 21 1983</u>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH CERTIFICATE IS ISSUED IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8310701
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Edward</i>	MIDDLE <i>Joseph</i>	LAST <i>Hibbitts Jr.</i>	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH 4	DAY 29	YEAR 1983	2b. HOUR 8:12 AM		
3. SEX <i>M</i>	4. RACE <i>W</i>	S. DATE OF BIRTH MONTH 8 DAY 22 YEAR 23 LAST BIRTHDAY 59 YRS.	6. AGE (IN YEARS MONTHS DAYS HOURS MIN.)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH 4	DAY 29	YEAR 1983	2d. HOUR 8:12 AM		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>						
11. CITY OR TOWN OF DEATH <i>Havre de Grace</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hospital Received</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>None</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
13a. STATE <i>Md</i>			13b. COUNTY <i>Cecil</i>			13c. CITY OR TOWN <i>Port Deposit</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>10 Wildwood Ln. 21904</i>				
14. FATHER'S NAME FIRST <i>Edward</i>			MIDDLE <i>Joseph</i>	LAST <i>Hibbitts Sr.</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Margaret</i>			Rutledge				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown			16b. SOCIAL SECURITY NO. -----			17. INFORMANT <i>Hospital Chart.</i>	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>4140</i> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Heart Disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(b) DUE TO, OR AS A CONSEQUENCE OF <i>ASCD - Diabetes</i>												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Lee E. Renyer</i>			TITLE (SPECIFY) M.D. <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED <i>4-29-83</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Lee E. Renyer</i>			ADDRESS <i>464 Allaire St Havre de Grace</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>April 30, 1983</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Cratin and Ferris</i>			23d. LOCATION CITY OR TOWNS <i>West Chester, Chester, Pa.</i>			COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Lee A. Patterson & Son</i>		ADDRESS <i>Perryville, Maryland</i>			25a. DATE REC'D. BY REGISTRAR <i>MAY 5 1983</i>			REGISTRAR'S SIGNATURE <i>John L. Clark</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, if medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	10/02		
										REG. NO.			
1 - FOR STATE REGISTRAR			LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FAMILY			JULY 20 83			6:30 PM				
WILLIAM GEORGE HINKLE													
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR JULY 20 02			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR 80 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD.				
10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN. HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Construction				
13a. STATE Md.			13c. CITY OR TOWN 21901			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 20 Beech St.				
14. FATHER'S NAME FIRST Charles MIDDLE H LAST Hinkle			15. MOTHER'S MAIDEN NAME FIRST Emily MIDDLE - LAST Davis										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No			16b. SOCIAL SECURITY NO. 165-05-149			17. INFORMANT Doreena M. Howington			ADDRESS 20 Beech St 21901 North East, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for item 18, Part 1.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5850 DUE TO, OR AS A CONSEQUENCE OF (b) CHF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal failure													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 4/28			21f. LOCATION STREET 415 CITY OR TOWN 83 COUNTY 11/28 STATE 19 83							
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Linda Fae Licit			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 4/29				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Linda Fae Licit			22e. ADDRESS 125 N Main St										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 4-29-83			23c. NAME OF CEMETERY OR CREMATORIAL Joseph B. Smith F.M. West Chester			23d. LOCATION CITY OR TOWN Chester COUNTY Pa.				
24. FUNERAL DIRECTOR NAME Stephen A. Hughes			ADDRESS Abingdon, Md. 21009			25a. DATE REC'D BY REGISTRAR MAY 2 1983			25b. REGISTRAR'S SIGNATURE John G. Daniels				
BP _____													
DHMH - 16 50M 4/82 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	1	0	7	0	3
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Thomas William Hutchens						April 15, 1983						6 ²⁰ P.M.				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Male			Caucasian		MONTH 9 - DAY 29 - YEAR 87			85			IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Virginia			U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY								
Bel Air			Bel Air Convalescent Center		Ret			Mechanic auto Self Employed								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Md.			Cecil		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			700 Biggs Highway			21911					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
Charles					Hutchens	Amelia					Sinclair					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
No			216-10-6786		Mr. H. Hutchens (w.t.e.) Son			Somewhere								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Pneumonitis																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure																
DUE TO, OR AS A CONSEQUENCE OF (c) ASLV D																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK: <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. HOW INJURY OCCURRED STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-15, 1983, to 4-15, 1983, that (I) (we) lost saw the deceased alive on 4-15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			22c. DEGREE					22d. DATE SIGNED								
William A. Tyson			MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					4-15-83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
William A. Tyson			Box 158 Millisville Md.													
23a. BURIAL, CREMATION, REMOVAL (F.Y.I.)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN		COUNTY						
Burial			4-19-83		Brookview Cemetery			Rising Sun		Cecil Md.						
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE								
Richard L. Goodie			APR 20 1983					John J. Conner								

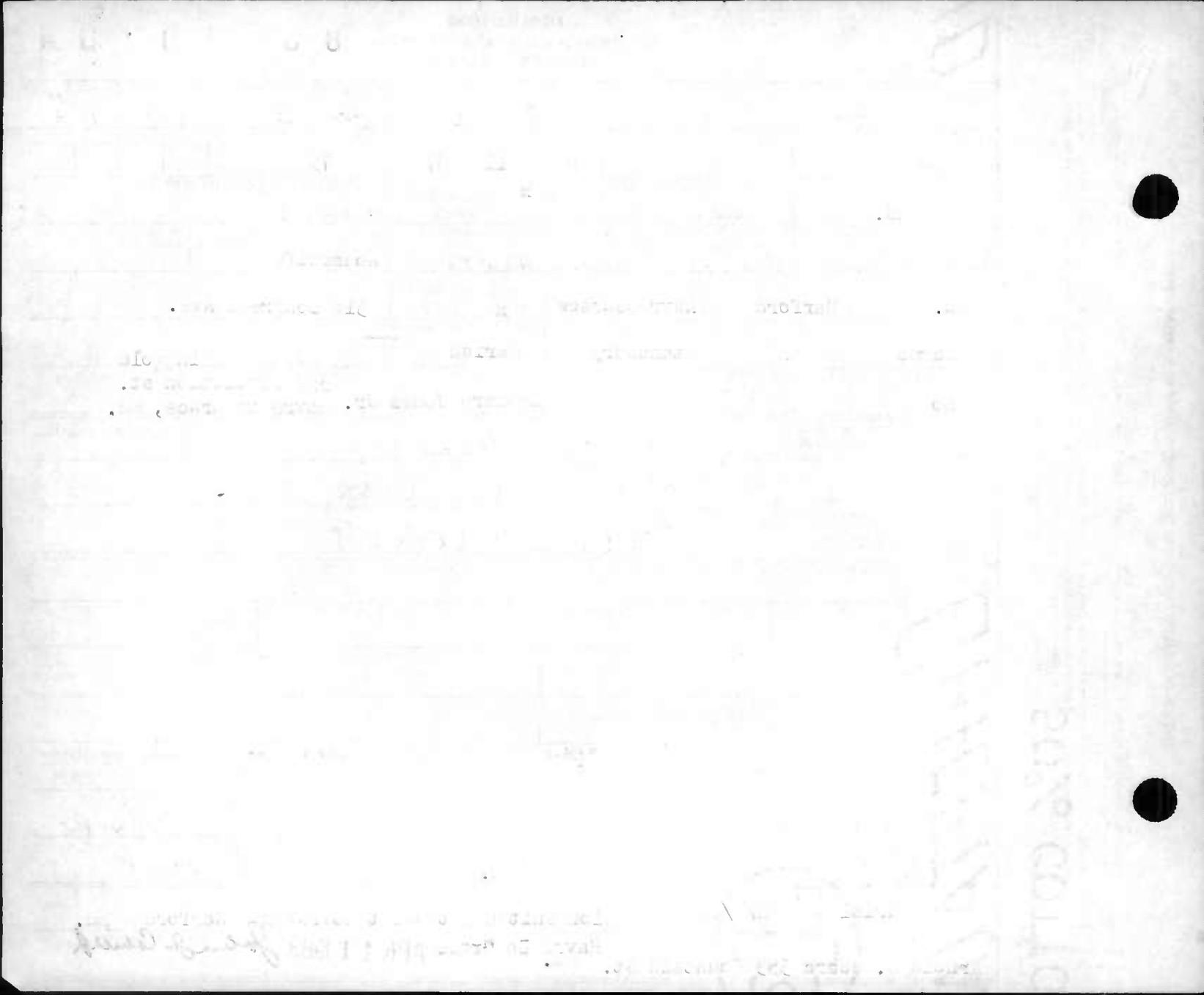
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifier must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 / 0 4	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
HAZEL V JONES						APRIL 4			1983		10 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		2b. HOUR	
F		B		8 MONTH 11 DAY 07			75			MONTHS DAYS		11 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Md.		USA					Harford						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Havre de Grace		Harford Memorial Hospital		Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Md.		Harford		Havre de Grace			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			318 Congress Ave. 21078			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		James	H	Stansbury	Marian								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			359 Revolution st.						
no				Leonard Jones Jr. Havre De Grace, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for Part 1a, b and c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
4100 CARDIAC ARREST													
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION													
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from APRIL 1, 1983, to APRIL 4, 1983, that (I) (we) last saw the deceased alive on APRIL 4, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			4/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
DONTE MONASKY			Havre de Grace and 21078										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/8/83			23c. NAME OF CEMETERY OR CREMATORIAL Union United Methodist			23d. LOCATION CITY OR TOWN Aberdeen			COUNTY Harford	
24. FUNERAL DIRECTOR NAME Arnold W. Beard 353 Fountain St.			ADDRESS Havre De Grace Md.			25a. DATE REC'D. BY REGISTRAR & REGISTRAR'S SIGNATURE APR 11 1983 John G. Cawie						STATE Md.	
BP _____													
DHMH - 16 50M 4/82 (VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	1	0	7	0	5
										REG. NO. 8310705						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
HARVEY P. JOURDAN						4 20 83			2 05 PM							
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)					
MALE			WHITE		4 8 07			76	YRS.		IF UNDER 1 YEAR					
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
MARYLAND			USA		WIDOWED			<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	12b. KIND OF BUSINESS OR INDUSTRY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
BEL AIR			BEL AIR CONVALESCENT CTA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1435 STAFFORD Rd.							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			15. MOTHER'S MAIDEN NAME								
MARYLAND			HARFORD		DARLINGTON			JANIE								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	16b. SOCIAL SECURITY NO.			17. INFORMANT							
BERNARD G.S.					JOURDAN	212-09-5399			ADDRESS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
16c. IF YES, GIVE WAR OR DATES			212-09-5399			MARGARET C. JOURDAN			DARLINGTON, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029			1 MONTH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension in ASCVD			DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension in ASCVD			5 YRS							
			DUE TO, OR AS A CONSEQUENCE OF (c) COPD			DUE TO, OR AS A CONSEQUENCE OF (c) COPD			10 YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Audrey Phillips MD			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/20/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Audrey Phillips MD			22e. ADDRESS DARLINGTON, MD 21034													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE APRIL 21, 1983			23c. NAME OF CEMETERY OR CREMATORIAL CRATIN + FERRIS			23d. LOCATION CITY OR TOWN WEST GOSHEN			COUNTY		STATE PA		
24. FUNERAL DIRECTOR NAME JOHN H. HARKIN'S 600 MAIN ST. DELTA, PA			ADDRESS			25a. DATE RECEIVED BY REGISTRAR APR 26 1983			REGISTRAR'S SIGNATURE John J. Connelly							

John H. Hancock 100 University Street Seattle WA

Ceremonial first 1/13 C.R.I.L. - Ceremonial first 1/13 C.R.I.L.

PAPE

DANIELSON NO

BERNARD E.S. TOUNAYE

NO

815-04-23A MARKET C. Tounayen 1432 STATEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8310706		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Palma MARGARET Jourdan						April 2 1983						2 10 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		WHITE		Nov. 4, 1905 ²		76			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10a. USUAL OCCUPATION (TYPE OR PRINT FOR REGULAR WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
MARYLAND		U.S.A.				HARFORD			KEY PUNCH OPERATOR			INSURANCE		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. STREET ADDRESS			12b. STREET ADDRESS			MD.				
HAVRE DE GRACE		HARFORD MEMORIAL HOSPITAL		1517 ARENA ROAD 21154			1525 SOUTH VIEW RD. BEL AIR, MARYLAND							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
MARYLAND		HARFORD		STREET		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			CHARLES HENRY EMMART			LILLIAN AGNES GARRETTSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		212-28-8540		PALMA N. DONER			Cardiac failure			5698				
DUE TO, OR AS A CONSEQUENCE OF (b) Septic peritonitis		DUE TO, OR AS A CONSEQUENCE OF (c) Perforated bowel												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
3/21/83		Perforated bowel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-19 19 83 to 4-2 19 83, that (I) (we) last saw the deceased alive on 4-2 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE				DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								4/3/83				
I.D. SOMERVILLE		400 LEWIS ST HAVRE DE GRACE												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE	
BURIAL		APRIL 5'83		Rock Run Meth Cem.			LEVEL			HARFORD			MARYLAND	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
HOWARD K. McCOMAS III		ABINGDON, MARYLAND		APR 8 1983						John George				

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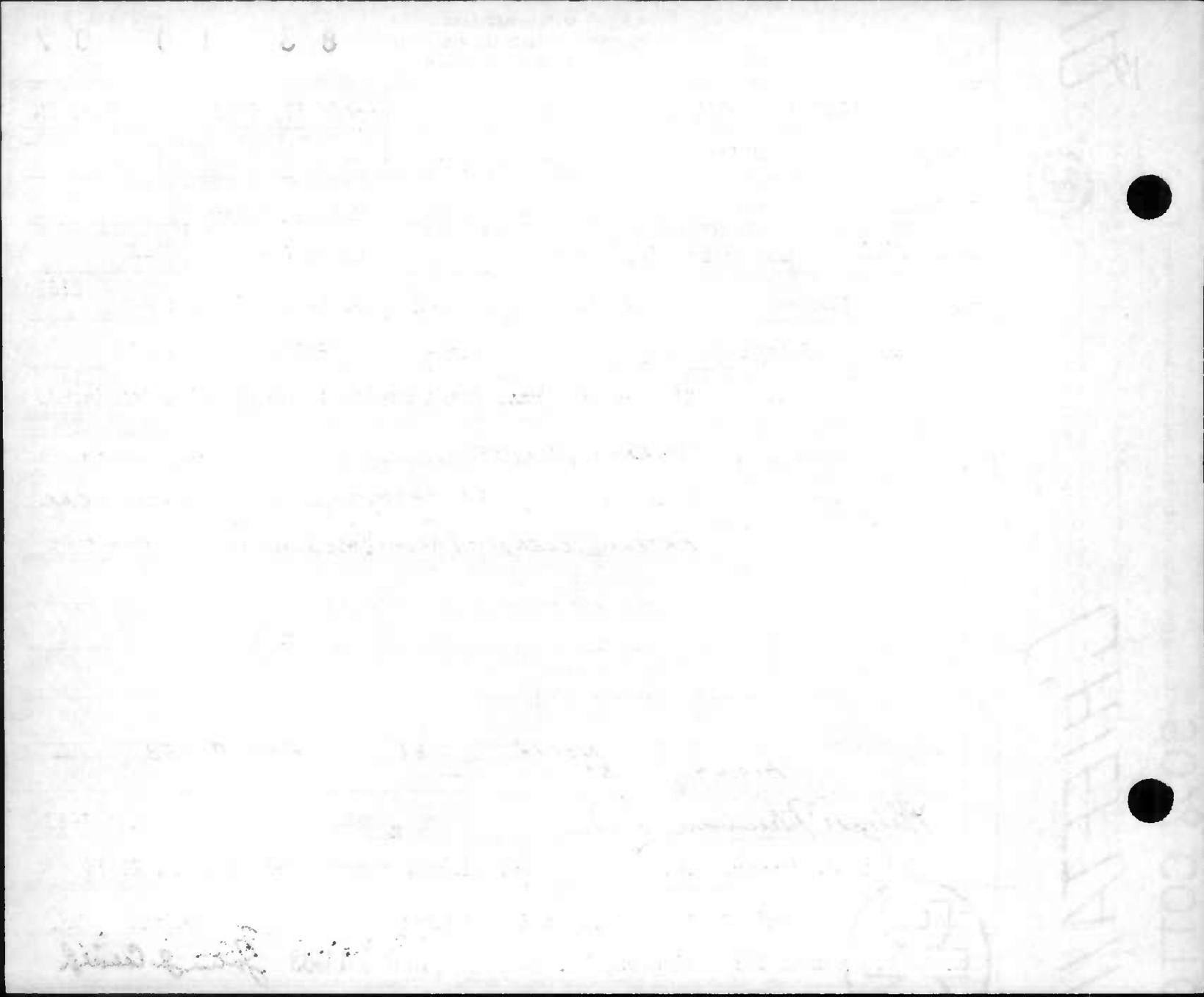


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 7 0 7				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
VIVIAN COLGAN KAHOE						April 11, 1983						3:57 PM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female			White			MONTH DAY YEAR April 22, 1897			85			IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
Maryland			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford County			MONTHS DAYS HOURS MIN.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			13d. INSIDE CITY LIMITS?			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Forest Hill			333 Bynum Ridge Road			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Housewife			MD.				
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Forest Hill			13d. STREET ADDRESS 333 Bynum Ridge Road			21050				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
Edward Joseph Colgan			Irene			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Mrs. Irene Boyle, 4 Forest Drive, BelAir, Md.			21014	
no			--			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Mrs. Irene Boyle, 4 Forest Drive, BelAir, Md.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) CARDIAC ARREST 4292 DUE TO, OR AS A CONSEQUENCE OF (b) T.I.A., SEIZURES DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROTIC (ARterio) VASCULAR DISEASE OLD AGE IN LAST YEAR													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Nov 14, 1961, to April 11, 1983, that (I) (we) last saw the deceased alive on April 4, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Philip W. Heuman, M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED Apr. 12, 1983							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 307 Hickory Avenue, Bel Air, Md. 21014													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN Hickory			COUNTY Harford Md.				
Burial			April 14, 1983			St. Ignatius Cemetery										
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR APR 14 1983 25b. REGISTRAR'S SIGNATURE John J. Corrigan													
Howard K. McComas III, Abingdon, Md. 21009																



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use on the burial-tranport permit. Then please remove carbon paper. If you need a copy of page 3, it should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 / 0 8			
1. FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Anna Marie Kane					April 10, 1983						7:10 A				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		Caucasian		Oct. 21, 1934			48								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford			MD.					
10. CITY OR TOWN OF DEATH Forest Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3560 Kreitler Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home								
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3360 Kreitler Road 21050					
14. FATHER'S NAME FIRST James		MIDDLE Webster		LAST McDonnal			15. MOTHER'S MAIDEN NAME FIRST Anna			MIDDLE Marie		LAST Ash			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-30-6271		17. INFORMANT Leo A. Kane			ADDRESS same as above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d			
1943 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Squamous Cell Carcinoma of the trachea</i>												15 yr			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (this hospital) attended the deceased from Jan 19 81 to April 10 19 83, that (1) (we) last saw the deceased alive on April 6 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.															
22b. SIGNATURE <i>Randall C. Cronin, Jr. M.D.</i>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/11/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Randall C. Cronin, Jr.		22e. ADDRESS 721 Wheeler School Rd. Whinsted Md. 21160													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/13/1983		23c. NAME OF CEMETERY OR CREMATORIAL Highview Mem. Gar			23d. LOCATION CITY OR TOWN Fallston, Harford, Md.								
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz		ADDRESS Jarrettsville, Md.			25a. DATE REC'D. BY REGISTRAR APR 13 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>							

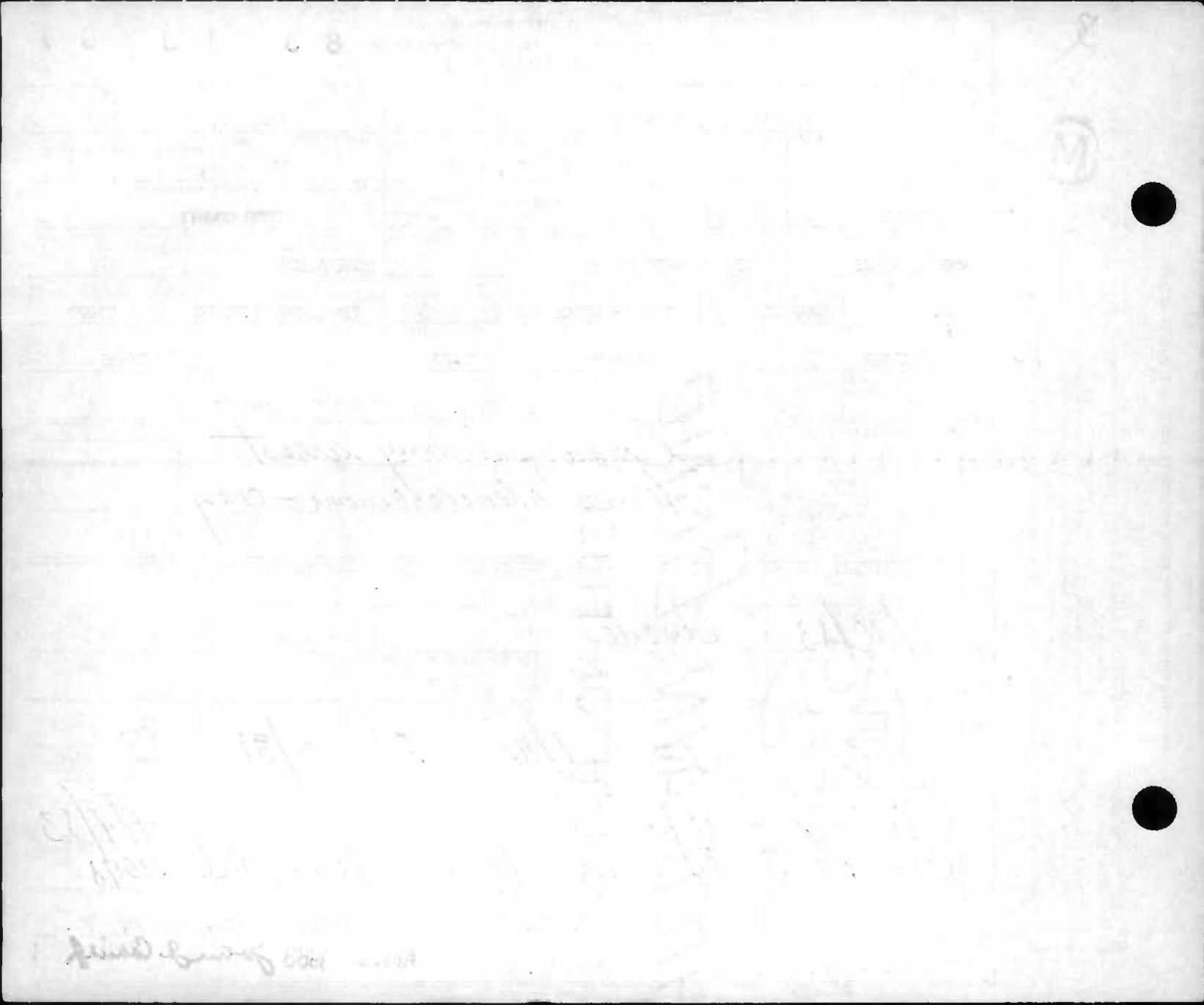
OF:7 601,01 201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 / 0 9					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
DOROTHY KENNEDY KEEN						April 3, 1983									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH DAY YEAR			72 YRS			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH			HARFORD COUNTY MD.					
Maryland		USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD COUNTY								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
HAVRE DE GRACE		734 ONTARIO STREET								HOMEMAKER					
13a. STATE MO.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 734 ONTARIO STREET		13f. ADDRESS 21078			
14. FATHER'S NAME FIRST CHESTER		MIDDLE		LAST KENNEOY			15. MOTHER'S MAIDEN NAME FIRST CLARA			MIDDLE		LAST OWENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
NO		218 80 4358		HARVEY V. KEEN (HUSBAND)			SAME AS #13e								
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and item 19c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Serous adenocarcinoma - ovary</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1830</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION <i>1/20/83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ascites</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>3/3 85/14</i>			21f. LOCATION STREET <i>83</i> to <i>5/31</i> 19 <i>83</i>			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>3/3 85/14</i> 19 <i>83</i> to <i>5/31</i> 19 <i>83</i> , that (I) (we) lost sight of the deceased alive on <i>3/3 85/14</i> 19 <i>83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													22c. DATE SIGNED <i>4/4/83</i>		
22b. SIGNATURE <i>Charles J. Foley Jr. MD</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME, TYPE OF PRACTICE <i>CHARLES J. FOLEY JR.</i>		22e. ADDRESS <i>Havre de Grace, Md 21078</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APRIL 7, 1983		23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY			23d. LOCATION CITY OR TOWN HARFORD, MO.								
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME, PA, HAVRE DE GRACE, MD. 21078		ADDRESS <i>APK 6 1983 John Smith</i>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Postage may be
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the
attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 7 1 0							
												REG. NO.							
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 29 12 P.M.							
			Lena Ethel Keith						April 22 83										
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2b. HOUR 29 12 P.M.							
Female		White		Feb. 27, 1908			75												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford			10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Havre de Grace Harford Memorial Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --		
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4207 Webster & Lapidum Roads		21078			Roads				
14. FATHER'S NAME FIRST Asbury			MIDDLE --			LAST Sparks			15. MOTHER'S MAIDEN NAME Martha			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			17. INFORMANT Mrs. Cleo B. Bandy, Havre de Grace, Md.			21078	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100			DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction			ADDRESS 1078			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 dy										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction			1078			1 dy										
DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			1078			1 dy										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 4-22, 19 83, to 4-22, 19 83, that (I) (we) last saw the deceased alive on 4-22, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Irvin Wachsmann MD			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 21078										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Irvin Wachsmann			22e. ADDRESS So. Union Ave Havre de Grace Md.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 24, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Darlington Cemetery			23d. LOCATION CITY OR TOWN Darlington ton COUNTY Harford STATE Md.										
24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009									25a. DATE REC'D. BY REGISTRAR APR 25 1983			25b. REGISTRAR'S SIGNATURE John J. Conner							

W

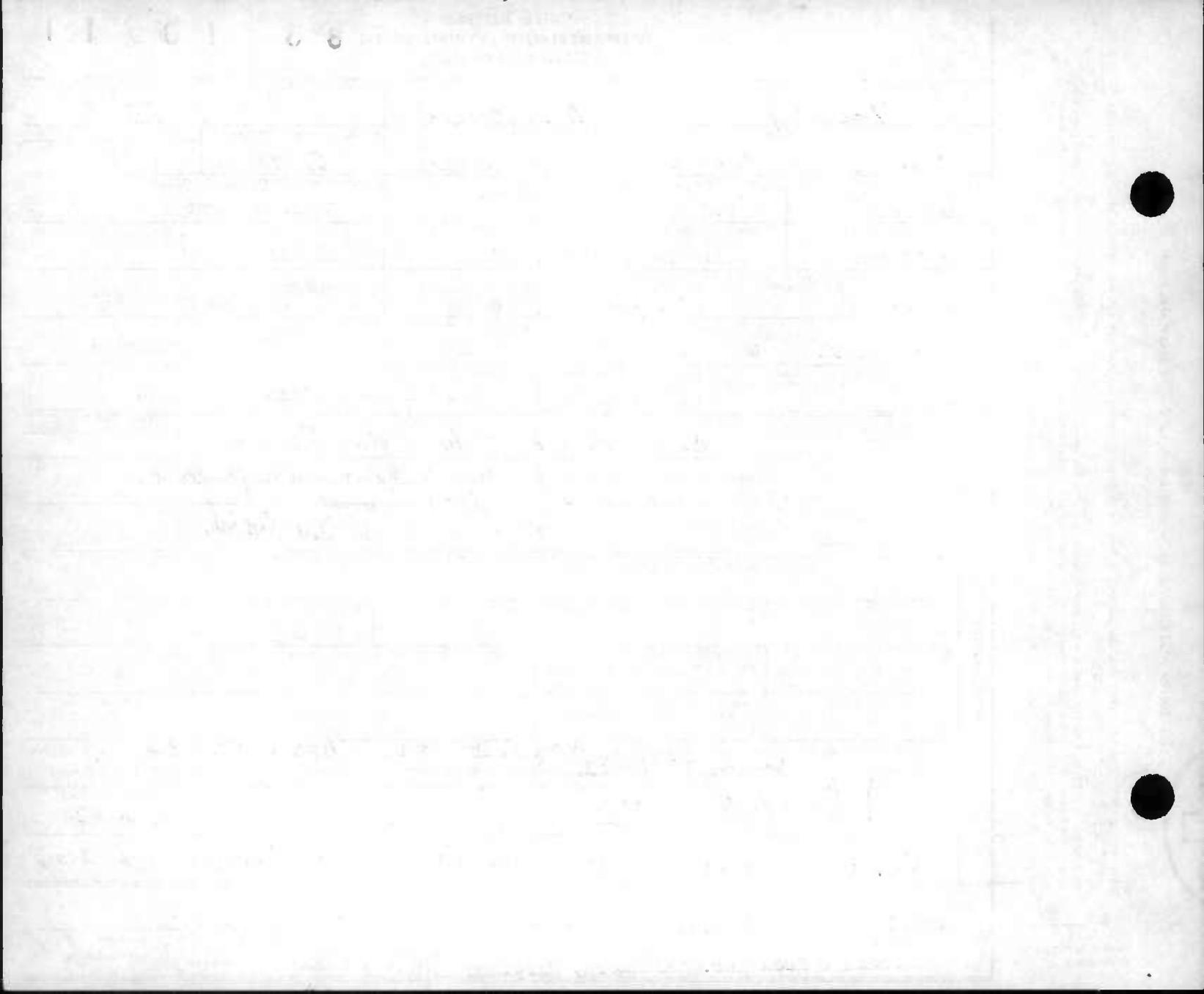


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	107	11	
										REG. NO.				
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
		<i>Dorothy</i>					<i>Kleiderlein</i>	<i>4 9 83</i>						<i>M</i>
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Female</i>		<i>White</i>		<i>9 2 12</i>			<i>24 70 yrs.</i>			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/>			NEVER MARRIED DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Maryland</i>		<i>U.S.A.</i>								<i>Harford County</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
<i>Fallston</i>		<i>Fallston General Hospital</i>								<i>Housewife</i>				
13a. STATE <i>Maryland</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>4642 Parkside Dr</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>McNicholas</i>				
14. FATHER'S NAME FIRST <i>Frederick</i>		MIDDLE <i>W</i>	LAST <i>Twele</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>			MIDDLE	LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS							
<i>No</i>		<i>218-12-8866</i>		<i>Bernard E Kleiderlein</i>			<i>Same</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>4049</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<i>Cardiac Arrest & Ac & Chr. Renal</i>				
{ DUE TO, OR AS A CONSEQUENCE OF (b) <i>HTAS evd</i> , <i>Dys</i> and										<i>Failure & Glomerulonephritis</i>				
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Anemia & Chr. Int. Cystitis</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>May 9th, 1981</i> , to <i>April 9th, 1983</i> , that (I) (we) last saw the deceased alive on <i>March 28th, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Murli Mathur</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>4-10-83</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MURLI MATHUR, MD</i>		22e. ADDRESS <i>1305 Fairview Rd., Fallston, Md 2104</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>4/13/83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood</i>			23d. LOCATION CITY OR TOWN <i>Baltimore, Maryland</i>			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <i>Leonard J Ruck Inc. Baltimore, Maryland</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>APR 11 1983</i>			REGISTRAR'S SIGNATURE <i>John J. Ruck</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	10	12		
										REG. NO.					
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST OIA	MIDDLE clyde	LAST Kilby	2a DATE OF DEATH			MONTH APRIL	DAY 11	YEAR 1983	2b. HOUR 7:15 A.M.	
3. SEX FEMALE		4 RACE White			5 DATE OF BIRTH MONTH March DAY 29 YEAR 1910			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS 73		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tugboat Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County			12b. KIND OF BUSINESS OR INDUSTRY Homemaker				
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (# NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1709 Fountain Green Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			13. STREET ADDRESS 1709 Fountain Green Road							
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air (21014)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1709 Fountain Green Road							
14. FATHER'S NAME STEPHEN		MIDDLE Troy	LAST SEXTON	15. MOTHER'S MAIDEN NAME Martha				16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 220-14-2180			17. INFORMANT (See) 838-4035 ADDRESS Mr. STEPHEN B. Kilby 1709 Fountain Green Road Bel Air, Maryland 21014										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))										19. DUE TO, OR AS A CONSEQUENCE OF (b) terminal cancer (c) (rectal) adenocarcinoma					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1982</u> to <u>July 15, 1982</u> , that (I) (we) last saw the deceased alive on <u>July 15, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED April 11, 1983					
22b. SIGNATURE <u>G. L. Louis, M.D.</u>		22d. DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 1 West Ring Factory Road, Bel Air, Md. 21014							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) G. L. Louis, M.D.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 13, 1983		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014		COUNTY	STATE			
24. FUNERAL DIRECTOR Joseph William Foster 25a. DATE REC'D. BY REGISTRAR APR 19 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield			25c. ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014										

ET I have been trying to
find another which I think
would be better. But now that the
new one is out I think it would be
better to go with it. It's
more reliable and easier to use.
I think it will be good for
the future.

ERIN: I think it's a good idea.
You might want to consider getting
one of those. It's a good investment.
I think you'll be happy with it.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on this certificate, any medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked **on**, Item 18 shows **any** injury, or other traumatic event, the Medicolegal Examiner shall be notified.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8	3	10713	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>William</i>	MIDDLE <i></i>	LAST <i>Kurtz</i>	2a. DATE OF DEATH MONTH <i>Aug.</i> DAY <i>8</i> YEAR <i>1899</i>			2b. HOUR IF UNDER 1 YEAR <i>4 22 83</i> IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
3. SEX <i>Male</i>			4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH <i>Aug.</i> DAY <i>8</i> YEAR <i>1899</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>			
10. CITY OR TOWN OF DEATH <i>FALLSTON</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FALLSTON GENERAL HOSPITAL</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Dealer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Oil</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Forest Hill</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>322 Bynum Road</i> MD. 21050	
14. FATHER'S NAME FIRST <i>Adam</i>			MIDDLE <i>Ebaugh</i>	LAST <i>Kurtz</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Elizabeth</i>			LAST <i>Thompson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-05-0575</i>			17. INFORMANT <i>Shirley K. Crumpler</i>			ADDRESS <i>Houston, Tex.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 2390 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Tumor of caecum</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i>April 22/83</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tumor of caecum</i>					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/16</i> , 19 <i>83</i> , to <i>4/22</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>4/22</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <i>April 22/83</i>	
22b. SIGNATURE <i>John</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>IAN J. SOMERVILLE</i>			22e. ADDRESS <i>400 LEWIS ST HARVE DE GRACE</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4/27/1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Deer Creek Cem.</i>			23d. LOCATION CITY OR TOWN <i>Forest Hill, Harford, Md.</i>		
24. FUNERAL DIRECTOR NAME <i>M. Thelma Kurtz Esq.</i>			ADDRESS <i>Jarrettsville, Md.</i>			25a. DATE RECEIVED BY DIRECTOR <i>AFB 2000</i>			25b. REGISTRATION SIGNATURE		

11

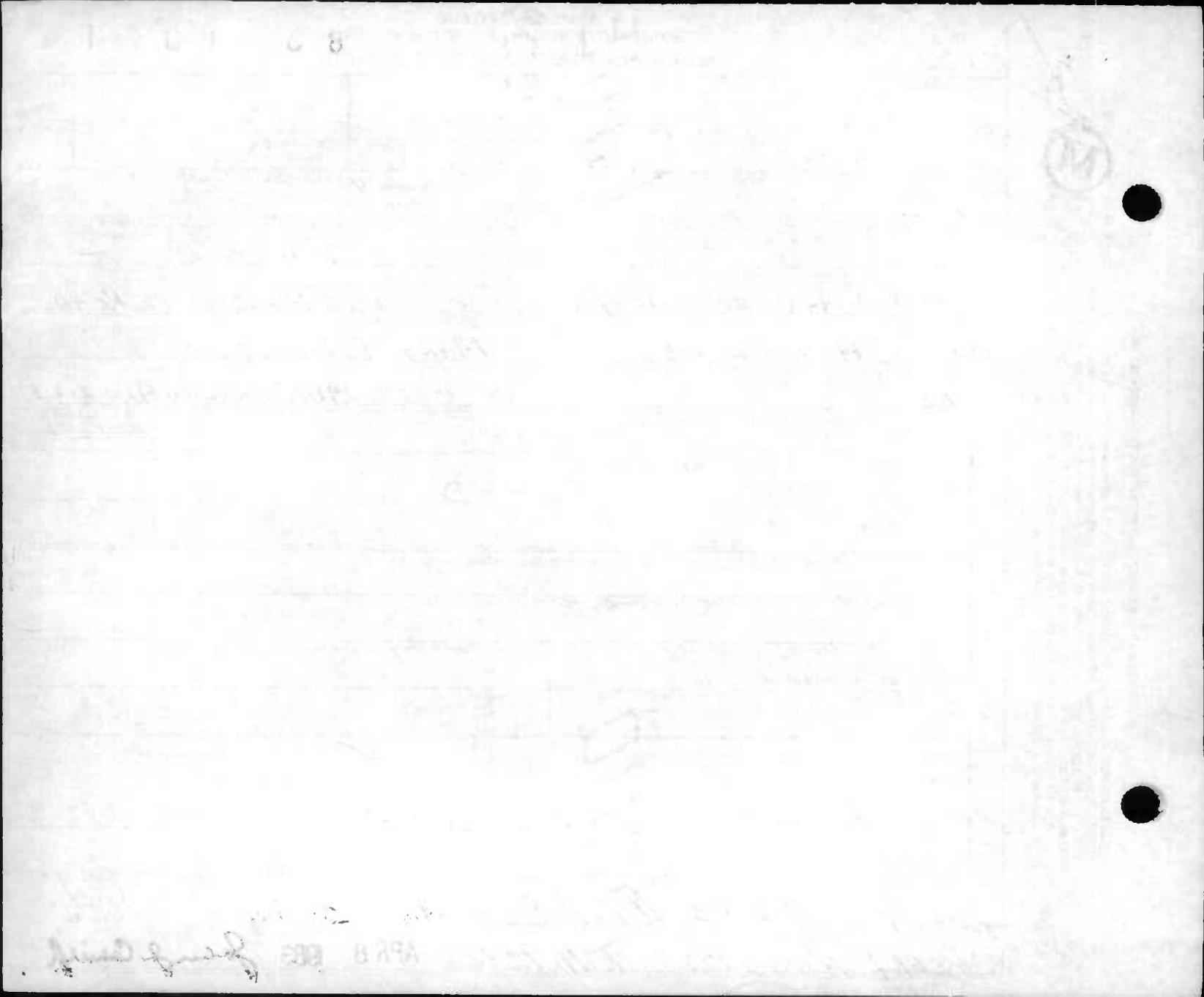
Союз православных христиан
помощи бедным и больным
и для поддержания христианской веры.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8 3 10714																	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH DAY YEAR		2b. HOUR													
		WILLIAM HENRY LARKINS								APR. 1 1983				1 P.M.															
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD				MONTH DAY YEAR		2d. HOUR										
MALE		BLACK		FEB. 22 '02			81 yrs.						APR. 1 1983						M										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
MARYLAND		U.S.A.								HARFORD				JOPPA				1502 MANCHESTER Road				Retired				MD.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS				14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Md		HARFORD		JOPPA						1502 MANCHESTER Road				JAMES H. LARKINS				MARY FORRESTER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				16c. INFORMANT				17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
No		218-03-9847				CARL LARKINS 2914 OAKFORD Ave 21215																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) CORONARY HEART DISEASE																													
4140 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.																													
(b) ASUVD																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?																	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																													
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE		Luis E. Renjel M.D.										TITLE (SPECIFY) M.D.		MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		Luis E. Renjel M.D.										ADDRESS		464 ALLIANCE ST. HAVRE DE GRACE,															
23a. BURIAL/CREMATION/REMOVAL (CITY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION CITY				23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE													
Aerial		4-6-83		Mt. Auburn Cem.				Baltimore				APR 8 1983				John J. Conigli													
24. FUNERAL DIRECTOR NAME		ADDRESS																											
Joseph L. Russ		2222 W. North Ave.																											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 10715					
1- STATE REGISTRAR			2a DATE KNOWN <input type="checkbox"/> MONTH 04 DAY 29 YEAR 83 OF ESTI- DEATH MATED									2b. HOUR 8 PM					
1. DECEASED NAME (TYPE OR PRINT)			FIRST JEROME			MIDDLE			LAST Mc Gregor			2c. DATE PRONONCED DEAD MONTH 4 DAY 29 YEAR 83			2d. HOUR 5 PM		
3. SEX M			4. RACE B			5. DATE OF BIRTH MONTH 5 DAY 21 YEAR 1967			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY					
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md			13b. COUNTY HARFORD			13c. CITY OR TOWN Havre de Grace			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 620 Freedom					
14. FATHER'S NAME FIRST Duncan MIDDLE M			LAST 70 GREGOR			15. MOTHER'S MAIDEN NAME FIRST CARRIE MIDDLE M			LAST REDDING								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 238-18-7700			16c. INFORMANT Hospital Chart			17. ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Coronary Heart Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF ASCVD (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) P.M.			21d. LOCATION STREET			CITY OR TOWN COUNTY STATE					
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21g. TITLE (SPECIFY) ACTUAL SIGNATURE Lewis E. Penney M.D. <i>Deputy</i>			MEDICAL EXAMINER		DATE SIGNED 4-30-83						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. ADDRESS 464 Allaire St Havre de Grace														
EXAMINER'S NAME (TYPE OR PRINT) Lewis E. Penney			23a. BURIAL, CREMATION, REMOVAL REMOVAL			23b. DATE 5-4-83			23c. NAME OF CEMETERY OR CREATORY RALEIGH Com.			23d. LOCATION CITY/TOWN RALEIGH, COUNT N.C STATE					
24. FUNERAL DIRECTOR NAME BULLOCK F/H 556 Lewis St ADDRESS HAVER DE GRACE, MD.			25a. DATE REC'D. BY REGISTRAR MAY 2 1983						25b. REGISTRAR'S SIGNATURE John G. Conner								
15M2/90																	

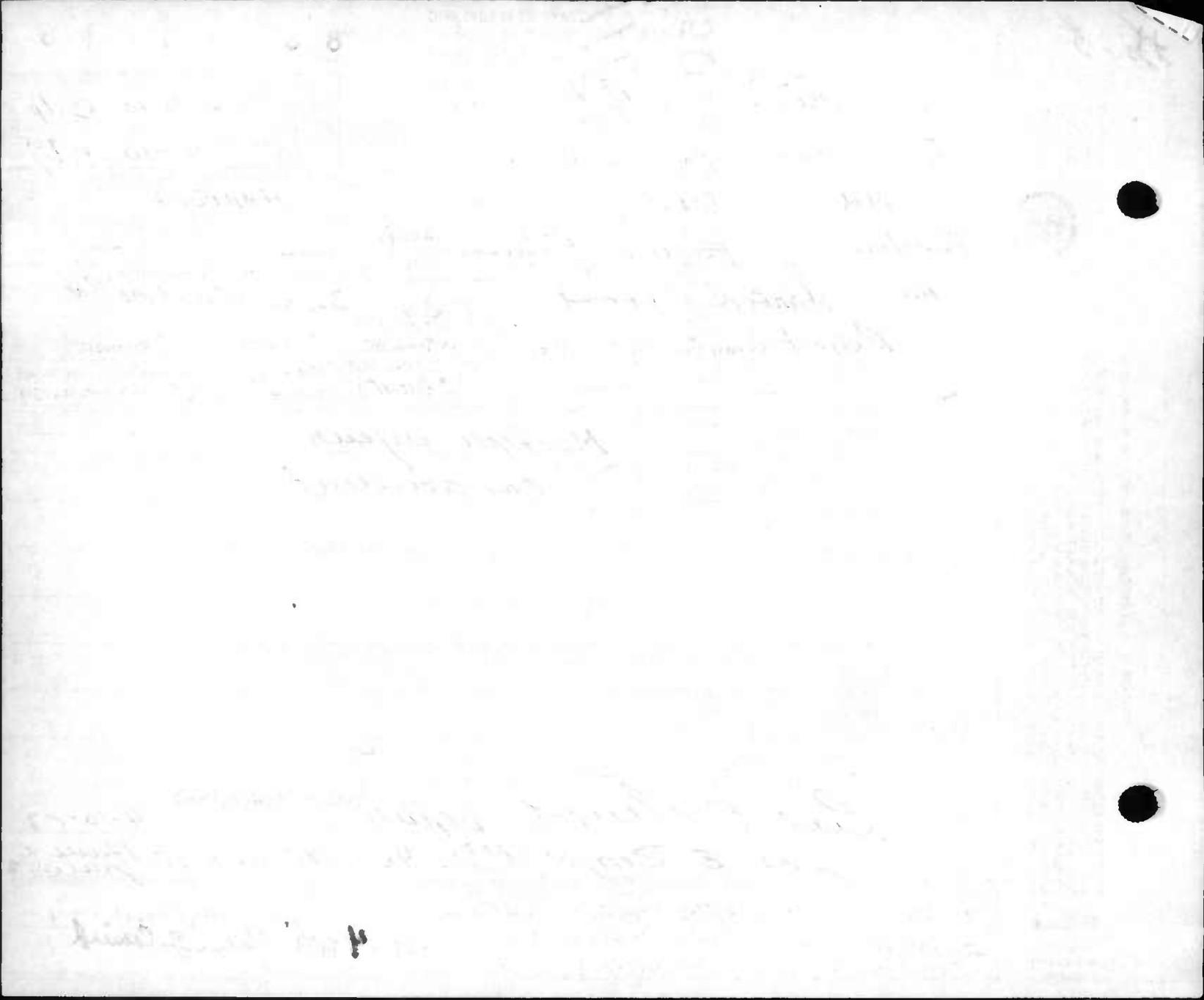
Anterior - Second & Third Branch.

Posterior - Second & Third Branch.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT FOR 72 HOURS AFTER DEATH. WITHIN 24 HOURS AFTER DEATH, WITHIN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 83	10/16	
1. DECEASED NAME (TYPE OR PRINT)			FIRST DANITA <i>Danita (Baby)</i>	MIDDLE LYNN <i>Lynne</i>	LAST MIDDLE MILLER <i>MILLER</i>			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH 4	DAY 10	YEAR 1983	2b. HOUR 1p m
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH 4	DAY 10	YEAR 1983	2d. HOUR 2p m	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?	9. MARRIED WIDOWED	10. NEVER MARRIED DIVORCED	8. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md			13b. COUNTY Harford			13c. CITY OR TOWN Fallston Street			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3231 Starbros Rd		
14. FATHER'S NAME FIRST Robert MIDDLE FRANKLIN LAST MILLER, Jr.			15. MOTHER'S MAIDEN NAME FIRST MICHELLE MIDDLE RENEE LAST BROWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT (Initials) 836-1951 Chest		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8199			IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>			Multiple causes car accident						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Luis E. Renjel</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER <i>Luis E. Renjel, M.D.</i>						DATE SIGNED 4-10-83		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 464 Allaire St, Bel Air, Md 21014			ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 13, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014			COUNTY	STATE	
24. FUNERAL DIRECTOR <i>Joseph Williams Foster</i>			ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			25a. DATE RECEIVED BY REGISTRAR APR 19 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>					



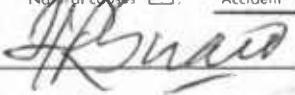
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 4. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETAINED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

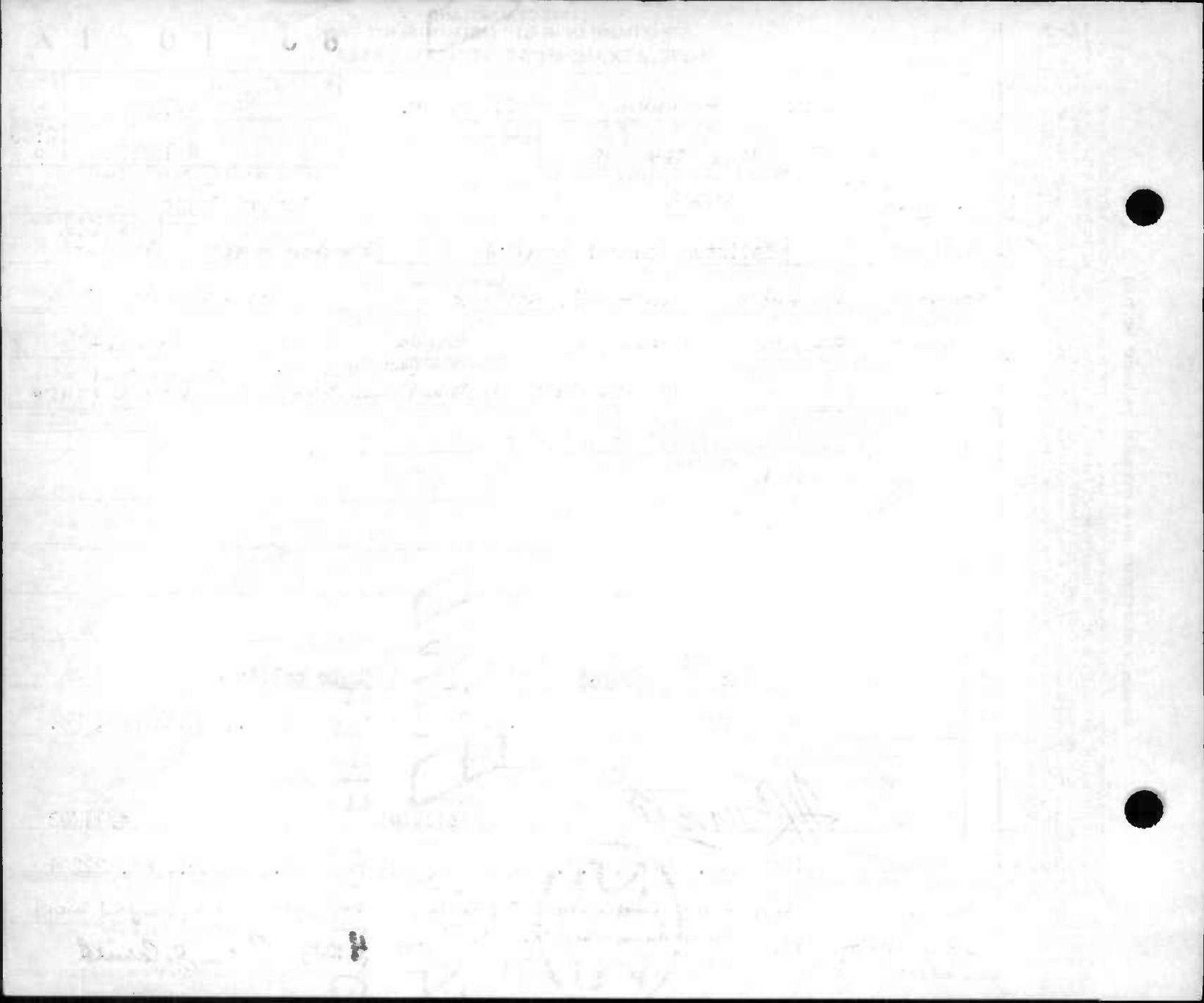
MEDICAL CERTIFICATION

1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 10717

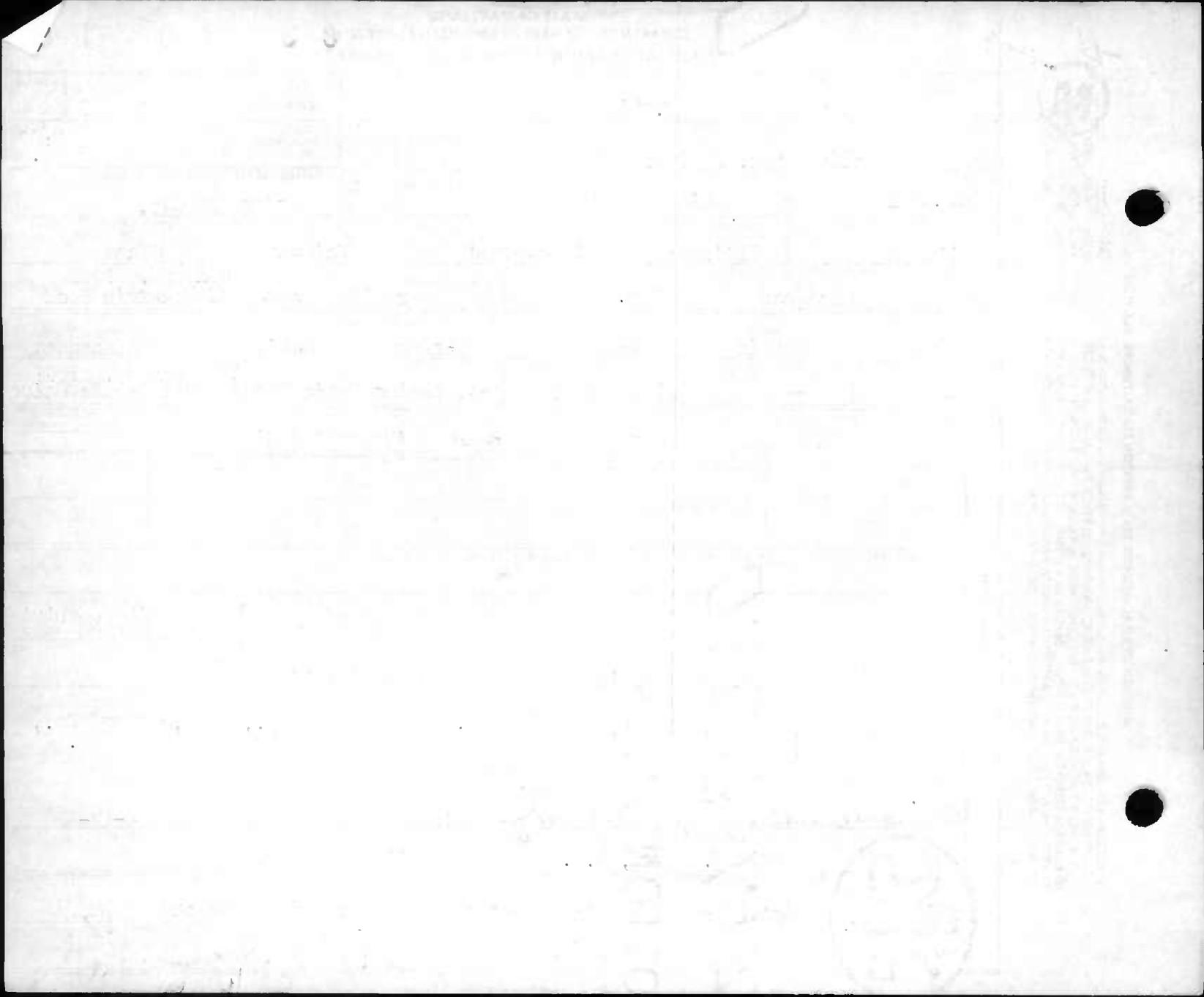
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Robert			FRANKLIN		Miller, Jr.	4/10/83	19			M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 24 HOUR P M	
Male	White	Oct. 26, 1964	18 yrs.			4/10/83	19			P M	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland		U.S.A.					Harford County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Fallston		Fallston General Hospital			Plumber Helper		Plumber				
13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Whiteford (21160)	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS MAIN STREET	2160					
14. FATHER'S NAME FIRST ROBERT		MIDDLE FRANKLIN	LAST MILLER, Sr.	15. MOTHER'S MAIDEN NAME FIRST STELLA	MIDDLE MAY	LAST COMER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-86-7995		17. INFORMANT (FATHER) 836-1931 ADDRESS Mr. Robert Franklin Miller, Sr. Street, Maryland 21154					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 12:40M 4/10/83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto collision							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET Rt. 165 Wheeler School Rd., Whiteford, Md.		CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		Hormez R. Guard, M.D.			ADDRESS	111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 13, 1983		23c. NAME OF CEMETERY OR CREMATORIAL BEL AIR MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014		COUNTY			STATE
24. FUNERAL DIRECTOR JOSEPH William Foster Joseph William Foster		ADDRESS W. Broadway & Williams St., Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR APR 14 1983		25b. REGISTRAR'S SIGNATURE P. Lane & Conard					
BP											
DHMH - 17 (VR A15 ME (5))											
20M 4/2											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR USE. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8 3 10718		
1. DECEASED NAME (TYPE OR PRINT)			FIRST Lester	MIDDLE Corbin	LAST Monk	2a. DATE KNOWN OF ESTI- DEATH MATED			XX	MONTH 4	DAY 16	YEAR 1983	2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 3, 1955	6. AGE (IN YEARS LAST BIRTHDAY) 28 yrs.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH 4	DAY 16	YEAR 1983	2d. HOUR A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.						
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trimmer			12b. KIND OF BUSINESS OR INDUSTRY Tree					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Joppa, Md. 21085 1303 South Old Mountain Road						
14. FATHER'S NAME FIRST John		MIDDLE Corbin		LAST Monk		15. MOTHER'S MAIDEN NAME FIRST Thelma			MIDDLE Marie		LAST Alexander			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. --		16c. INFORMANT ADDRESS Mrs. Thelma Marie Trout, 3402 Pebble Drive										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Gunshot wound of Head (Unspecified) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? (head only) YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY ? P.M. 4 16 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET 1303 S. Old Mountain Rd., Joppa, Harford Co., CITY OR TOWN Md. STATE								
22a. I certify that I took charge of the remains described above, held or death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) Assistant MEDICAL EXAMINER												DATE SIGNED 4-17-83		
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smyth, M.D.									ADDRESS 111 Penn Street		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 19, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN Bel Air, Harford COUNTY Md. STATE					
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			25a. DATE REC'D. BY REGISTRAR APR 19 '83			25b. REGISTRAR'S SIGNATURE Jean S. ...								
DHMH - 17 (VR A15 ME (5)) 20M 4/82														

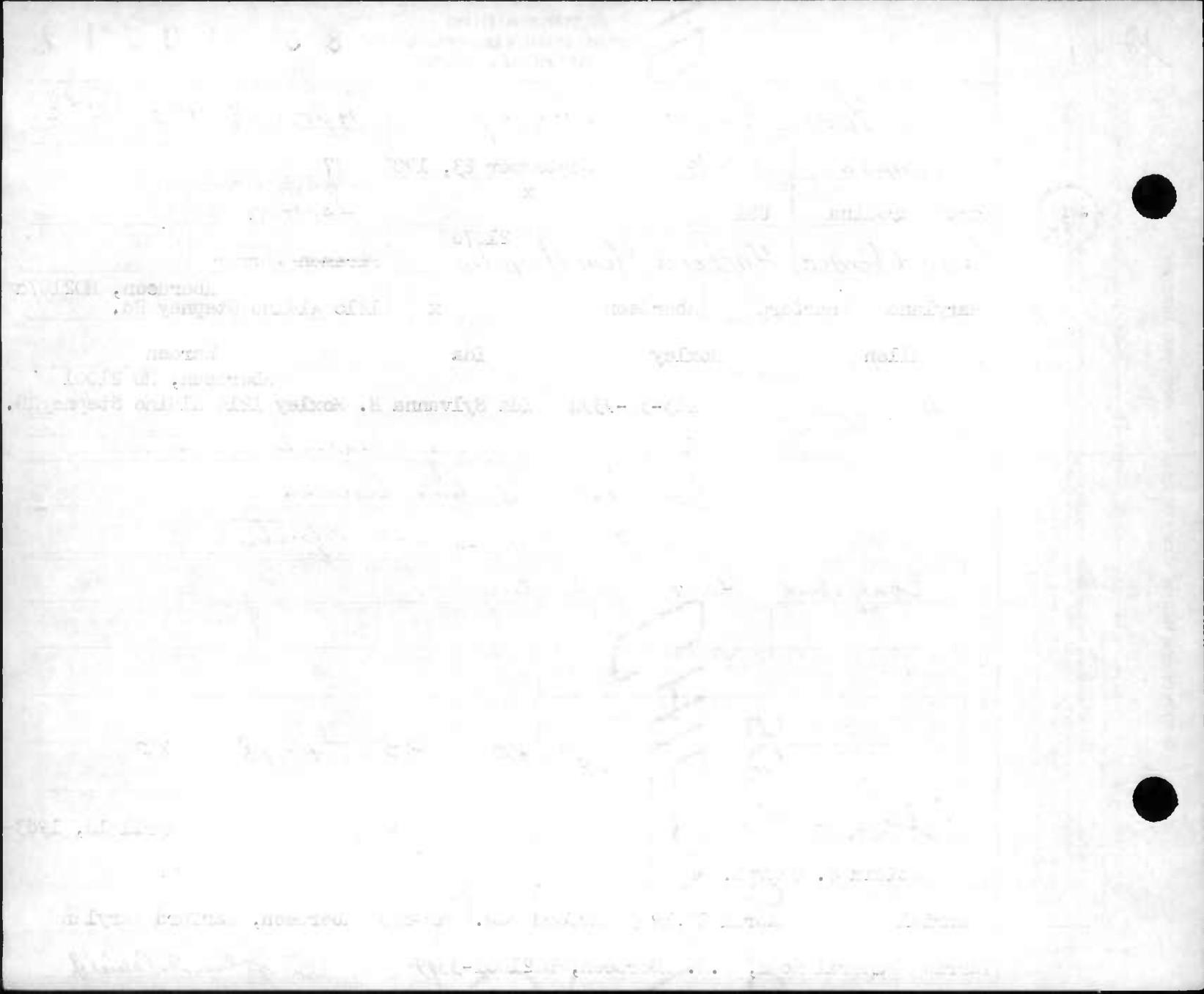


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the medical examiner's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 7 1 9	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>Kam Robert Moxley</i>						<i>April 18, 1983</i>						<i>3 27 AM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
<i>male</i>			<i>White</i>			<i>September 23, 1905</i>			77			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>North Carolina</i>			<i>USA</i>			<input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>Harford</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Havre de Grace</i>			<i>Hartford Mem. Hospital</i>			<i>Fireman Farmer</i>			<i>Aberdeen, MD 21001</i>				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
<i>Maryland</i>			<i>Harford</i>			<i>Aberdeen</i>						<i>1216 Aldino Stepney Rd.</i>	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
			<i>Allen</i>		<i>Moxley</i>				<i>Ida</i>		<i>Warden</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
<i>NO</i>			<i>213-38-9394</i>			<i>Sylvanna N. Moxley</i>			<i>Aberdeen, MD 21001</i>			<i>1216 Aldino Stepney RD.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pul mon any Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Recurrent Cardiac Arrhythmia</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute myocardial infarction</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive heart failure</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>3-28</i> , 19 <i>83</i> , to <i>4-18</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>4-18</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Leticia S. Galvez</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>April 18, 1983</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Leticia S. Galvez, MD</i>			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>April 20, 1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Harford Mem. Gardens</i>			23d. LOCATION CITY OR TOWN <i>Aberdeen, Harford</i>			COUNTY	STATE <i>Maryland</i>
24. FUNERAL DIRECTOR NAME <i>Tarring Funeral Home, P.A.</i>			ADDRESS <i>Aberdeen, MD 21001-339</i>			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 7 2 0				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Susan J Ntyard						4 30 83						1045 AM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female			White			MONTH 2 DAY 22 YEAR 50			33 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Penns.			United States						Harford							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Fallston			Fallston General Hospital			Admin specialist Civil Service										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21160	
			Md.			Harford			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1929 Susquehanna Hall Rd.				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	Goss				
Paul					Baker	Clemens										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Whitford, MD				
(If Yes, give war or dates)			217 583093			Kenneth A. Nugard			1929 Susquehanna Hall Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
7452 (b) <u>ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>tetralogy of Fallot</u> DUE TO, OR AS A CONSEQUENCE OF												24h.				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												years.				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Paul H. Chew</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 4/30/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Chew</u>			22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>Cremation May 4, 1983</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Crafan & Ferris</u>			23d. LOCATION CITY OR TOWN <u>West Chester Chester PA</u>							
24. FUNERAL DIRECTOR NAME			ADDRESS <u>John H. Harkins 600 Main St. Delta, PA</u>			25a. DATE REC'D. BY REGISTRAR <u>MAY 3 1983</u>			25b. REGISTRAR'S SIGNATURE <u>John H. Harkins</u>							

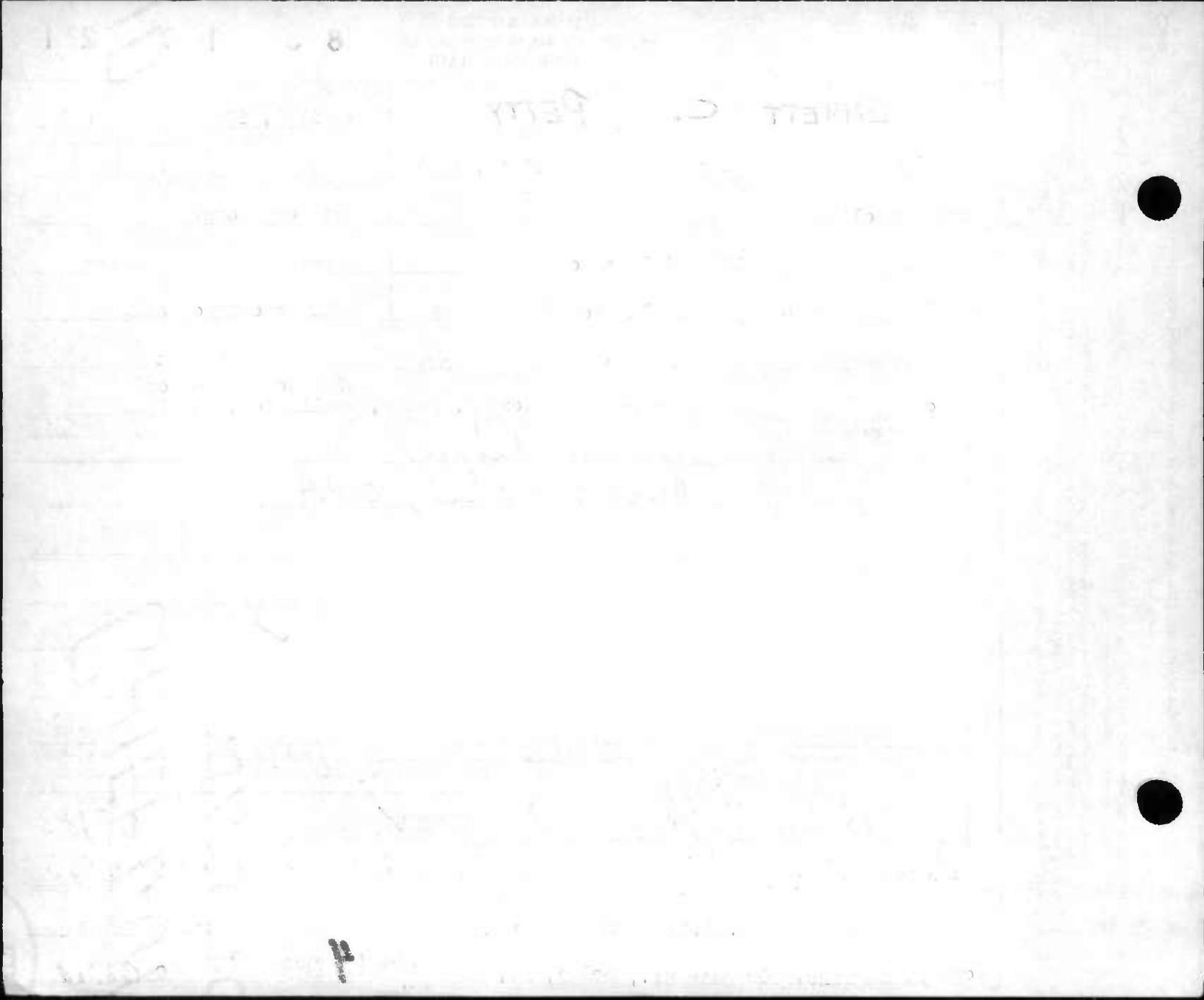
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 / 2 1
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
EMMETT C. PETTY					PETTY	April 8, 1983				9:55 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH DAY YEAR April 19, 1904		78		MONTHS DAYS		HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2107 Fairlane Road		
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4020 Conowingo Road		12b. KIND OF BUSINESS OR INDUSTRY Dairy		
14. FATHER'S NAME FIRST Oscar		MIDDLE Petty		LAST		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE		LAST Hendrix		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 238-05-7060		17. INFORMANT Nora R. Petty, Darlington, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for terminal and immediate causes) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2019 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkins disease (c) ASND c angina, CRA		ADDRESS 4020 Conowingo Road		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1/12/83		21f. LOCATION STREET 1/12/83		CITY OR TOWN 1/12/83		COUNTY 1/12/83		STATE 1/12/83		
22a. I certify that (I) (this hospital) attended the deceased from 1/22/83 , 19_____, to 1/22/83 , 19_____, that (I) (we) lost the deceased olive on 1/22/83 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Brian T. Yeo		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/9/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN T Yeo		22e. ADDRESS So. Union Ave HAURE de GRACE MC 21078										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 11, 1983		23c. NAME OF CEMETERY OR CREMATORIAL New Bridge Baptist		23d. LOCATION CITY OR TOWN Rising Sun		COUNTY Cecil		STATE Maryland		
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, Pa.		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 14 1983		25b. REGISTRAR'S SIGNATURE 7 - 2. Canfield						



Page 3
Form 3
Part 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	1	0	1	2	2
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
<i>MARTHA E QUESENBERY</i>						<i>4 - 19 - 83</i>						<i>4:00 AM</i>						
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS				
<i>Female</i>			<i>White</i>		<i>March 1 1896</i>			<i>87</i>			<i>YRS.</i>			<i>MONTHS DAYS HOURS MIN.</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
<i>Maryland</i>			<i>USA</i>		<i>HARFORD</i>						<i>HARFORD</i>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>FALLSTON</i>			<i>FALLSTON GENERAL</i>									<i>Homemaker</i>			<i>Home</i>			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
<i>Maryland</i>			<i>Harford</i>		<i>Fallston</i>						<i>1301 Carrs Mill Road</i>			<i>21047</i>				
14. FATHER'S NAME FIRST			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> . DUE TO, OR AS A CONSEQUENCE OF (b) <i>CVA CHF</i> . DUE TO, OR AS A CONSEQUENCE OF (c) <i>Parkinson's Disease</i> . APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> .			
<i>John</i>			<i>Livingston</i>		<i>Katherine</i>				<i>No</i>			<i>Fallston, Maryland 21047</i>			<i>L.Ray Quesenberry, Jr., 1301 Carrs Mill Road,</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
			<i>19</i>															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
									<i>4-18-83</i>		<i>4-19-83</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>4-18-83</i> to <i>4-19-83</i> , that (I) (we) last saw the deceased alive on <i>4-18-83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>B.D. PAREKH</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>4-19-83</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. D. PAREKH</i>			22e. ADDRESS <i>1908 Harford Rd Fallstn MD 21047</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>04/22/83</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Johns Catholic Cem. Hydes</i>			23d. LOCATION CITY OR TOWN <i>Baltimore</i>			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME <i>Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399</i>			ADDRESS						25a. DATE REC'D. BY REGISTRAR <i>APR 25 1983</i>			25b. REGISTRAR'S SIGNATURE <i>Jeanne L. Carroll</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8310123			
												REG. NO.			
1 - STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			BLANCHE RUNKLES			REDMOND			04 14 83			135 AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE			WHITE			MONTH DAY YEAR			86			MONTHS DAYS		HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
FALLSTON			FALLSTON GENERAL HOSPITAL			XXXXXX			XXXX Sewing Operator			21251			
13a. STATE NJ			13b. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2200 21st ODELL AVENUE			INT CENTER			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
George S. Runkles			Laura V. Fogel												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS									
UNKNOWN NO			218-05-6599			LYNN P. LUKAS 2517 FAIRWAY DR BELAIR, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: 4264 IMMEDIATE CAUSE (a) CARDIO - PULMONARY ARREST															
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF CHRONIC PROGRESSIVE CARDIOMYOPATHY															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: COPD															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
19c.			19d.			20c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (This Hospital) attended the deceased from 4/13/83 19 to 4/14/83 19, that (I) (we) last saw the deceased alive on 4/13/83 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.															
22b. SIGNATURE David R. Padriño, M.D.			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 57 E. Broadway, Bel Air, 21014			22f. DATE SIGNED 4/14/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID R. PADRINO, M.D.			22e. ADDRESS 57 E. Broadway, Bel Air, 21014			23d. LOCATION CITY OR TOWN Cockeysville			23e. COUNTY Balto., Md.			STATE			
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23c. DATE April 16, 1983			23d. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Cem.			23e. LOCATION CITY OR TOWN Cockeysville			23f. COUNTY Balto., Md.			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.			24b. ADDRESS 1050 York Road Towson, Md. 21204			24c. DATE REC'D. BY REGISTRAR APR 15 1983			24d. REGISTRAR'S SIGNATURE John J. Canfield						

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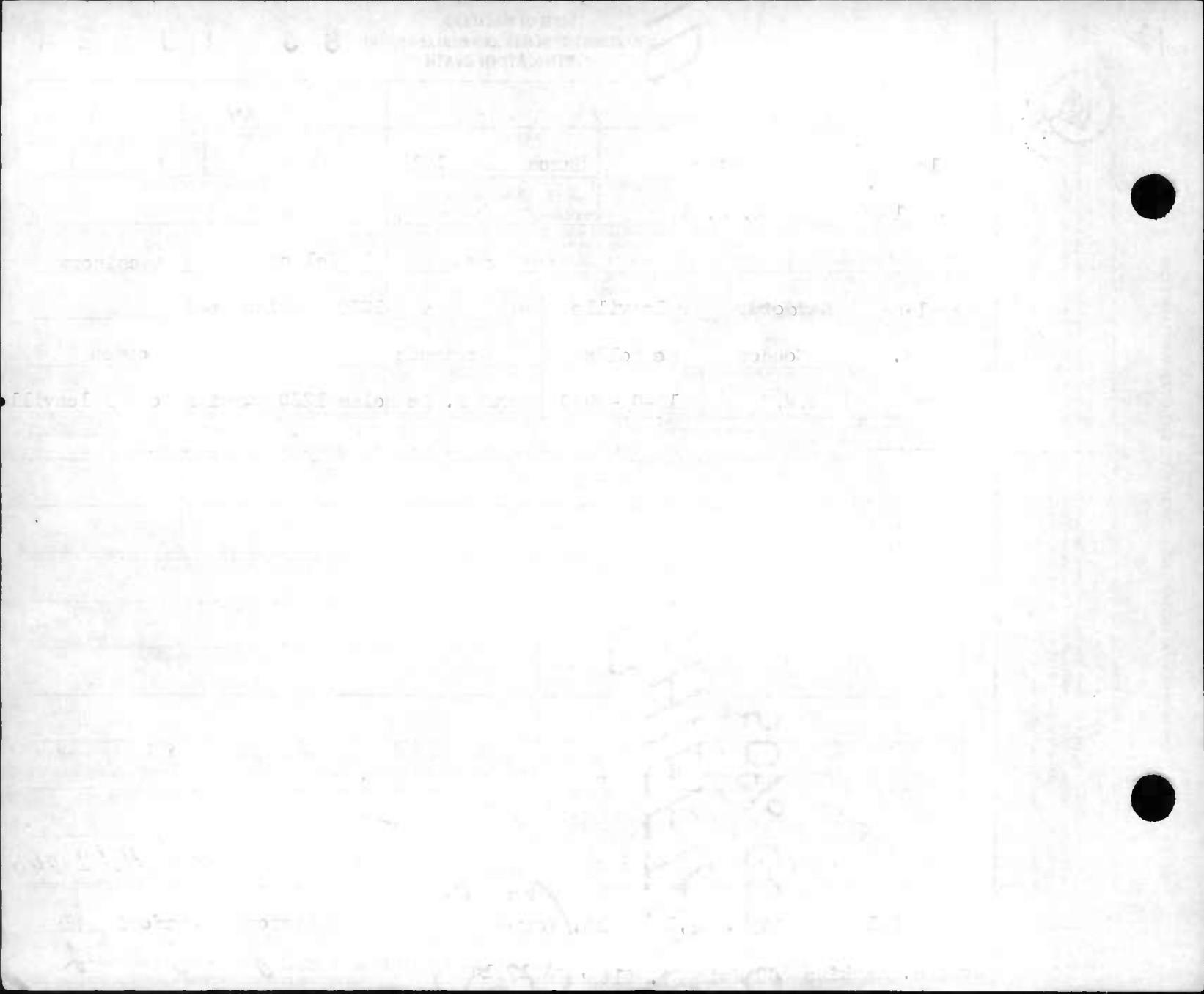
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	3	10	24	
												REG. NO.				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			RICHARD W. Reynolds						4-24-83			4:47 A.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			MONTH March DAY 8 YEAR 1918			65			MONTHS YRS.		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U. S. A.						HARFORD							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
FALLSTON			FALLSTON GENERAL Hosp			Welder			Machinery			21132				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Harford		Pylesville					1200 Harkins Road						
14. FATHER'S NAME			FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME											
			W. Coudon Reynolds		Gertrude						LAST Cowden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			MD				
Yes			W.W.2 216-05-3930			Ruth L. Reynolds			1200 Harkins Road Pylesville							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)																
DUE TO, OR AS A CONSEQUENCE OF																
DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
			HOUR A.M. MONTH DAY YEAR			P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-24-83</u> , to <u>4-24-83</u> , that (I) (we) last saw the deceased alive on <u>4-24-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED				
22b. SIGNATURE <u>M.S. Sharaf El-Deane</u> DEGREE <u>MD</u>												ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
M.S. SHARAF EL-DEANE			PO. Box 935 Edgewood, MD 21040													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION			23e. COUNTY STATE				
Burial			Apr. 27, 1983			Mt. Vernon			Whiteford			Harford MD				
24. FUNERAL DIRECTOR NAME			ADDRESS									25a. DATE REC'D. BY REGISTRAR				
John H. Harkins			600 Main St. Dept. a, PA 17314									APR 27 1983 John J. Connelly				
BP _____																
DHMH - 16 50M 4/82 (VRA 15, 4)																

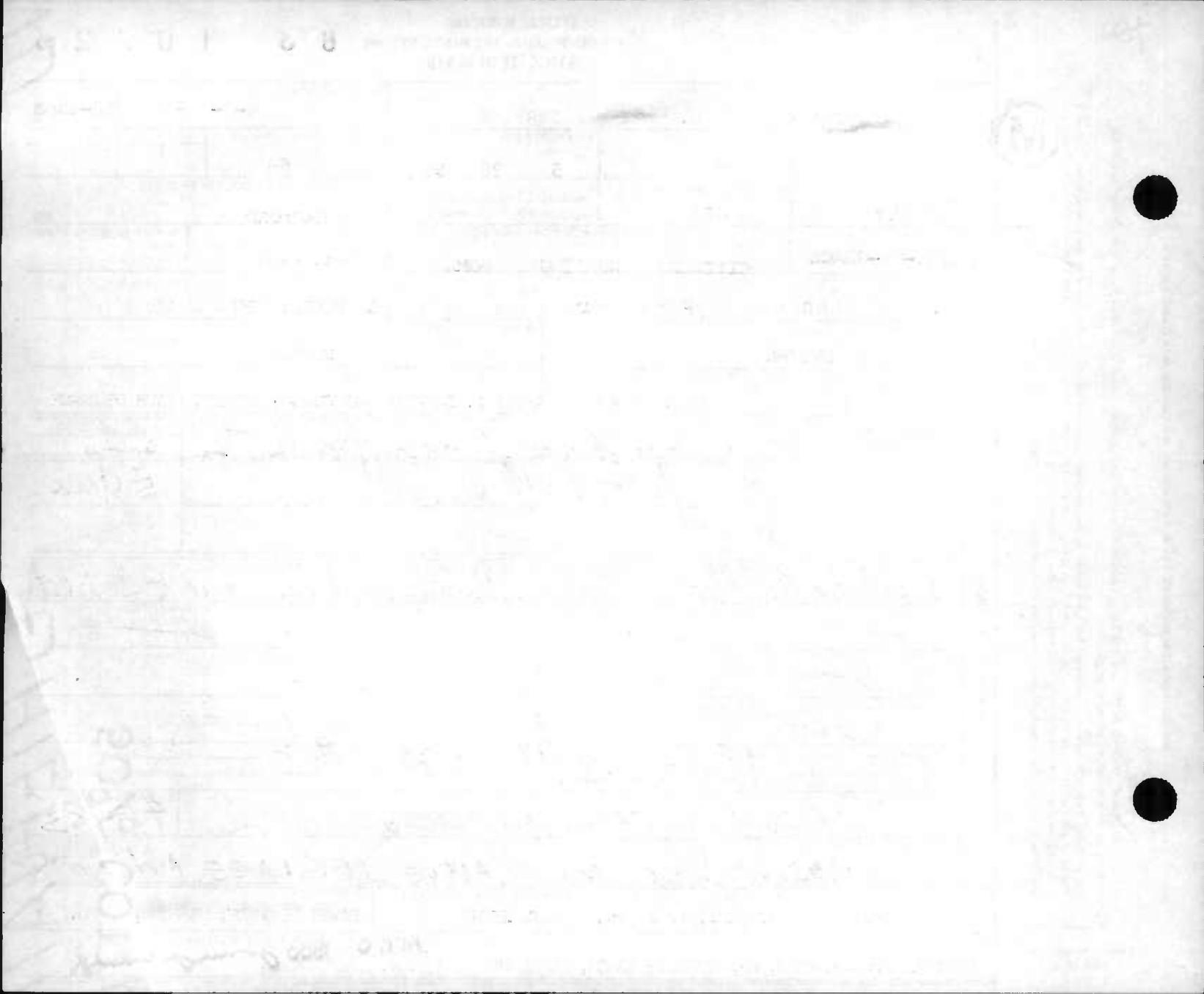


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	10/25		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
ANNIE				M.	SARVINO		4-2-			83			12-45pm M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
F		W		MONTH	DAY	YEAR	84			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
ITALY		USA					HARFORD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HAVRE-DE-GRAVE		CITIZENS NURSING HOME										HOMEMAKER		MD.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET ADDRESS 607 PEARL STREET 21078	
13b. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE			13d. FIRST		13e. MOTHER'S MAIDEN NAME UNKNOWN		13f. LAST				
14. FATHER'S NAME FIRST		MIDDLE		LAST											
UNKNOWN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		217 03 0887 B		LOUIS A. SARVINO			613 JUNIATA STREET, HAVRE DE GRACE			3 days					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: 4292												5 years.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF A-S.C.V.D.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes Mellitus, Chronic Brain Syndrome due to Senility.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, SIGNATURE MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/>				21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FIRM, ETC.			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 2 1983				22b. TIME OF INJURY 19 78			22c. HOW INJURY OCCURRED 19 83			to April 2 1983		that (I) (we) last saw the deceased alive on April 2 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22d. SIGNATURE Edward C. Loo, M.D.				22e. DEGREE MD			22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22g. DATE SIGNED 4/2/83					
22h. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. Loo, M.D.				22i. ADDRESS HAVRE DE GRACE, MD. 21078											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL MT. ERIN CEMETERY			23d. LOCATION CITY OR TOWN HAVRE DE GRACE, HARFORD, MD.			25a. DATE REC'D. BY REGISTRAR					
BURIAL		APRIL 4, 1983													
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME, PA, HAVRE DE GRACE, MD 21078												25b. REGISTRAR'S SIGNATURE H. J. Young, Esq.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	10126			
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR 45		
JOHN			L.	Scott		4			08	83	8 PM			
3. SEX			4. RACE	5. DATE OF BIRTH	6. AGE	(IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
M			W	MONTH 6 DAY 12 YEAR 12	70	MONTHS			DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
West Virginia			U.S.A.						HARFORD County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Fallston, Md.			Fallston General Hosp.			Janitor			Public Schools			21132		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Harford			Pylesville						1020 Old Pylesville Rd.		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
George			W.	Scott		Mary			Ella	Crookshank				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes			WWII 233-28-7069			James L. Scott, Box 25, Whiteford, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ATHEROSCLEROTIC HEART DISEASE</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WE'RE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
NA			N/A			N/A			N/A					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			N/A					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A			21f. LOCATION STREET N/A			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/31/87</u> , to <u>4/8/87</u> , that (I) (we) lost saw the deceased alive on <u>4/8/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Ramesh Karody</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/8/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23d. BURIAL, CREMATION, REMOVAL (SPECIFY)			23e. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			25d. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE
RAMESH KARODY			200, RICTON AVE, PARLESTON MD 21047			Burial			Old Brick Church			APR 13 1983		J. Harkins
24. FUNERAL DIRECTOR NAME			ADDRESS			25d. LOCATION CITY OR TOWN			COUNTY			STATE		
John H. Harkins			600 Main St. Delta, PA			Hillsboro, Pocahontas, W. Va.								

8.20. precipitate
dark reddish brown. short, irregular, thin, w.
irregularly wavy edges x. wavy, broad base
dark brown wavy wavy wavy wavy

8.20. precipitate dark reddish brown wavy
wavy wavy wavy wavy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 2 & 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Bernard			Joseph		SIMMONS ST.	July 30th			1983	4	9	44 M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			White			MONT TH DAY YEAR			81			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Maryland			U.S.A						HARFORD			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BEL AIR			505 Camelot Drive, BelAir, Md.			Retired Police			Balto. City				
13a. STATE Md.			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
			Baltimore						3131 Chesterfield Ave.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			21014			21213				
Raphael			PELAGIA						PLOSINSKA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			219-290026			Helena D. Simmons, same address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of Prostate</u> <u>1850</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BONE METASTASIS</u> (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4.9.1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>D. L. Pirovolidis</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/9/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. L. Pirovolidis</u>			22e. ADDRESS 1716 HARFORD Rd. FALLSTON, Md. 21047										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/12/83			23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cem.			23d. LOCATION CITY OR TOWN Balto., Md. COUNTY STATE				
25a. FUNERAL DIRECTOR NAME Schimmler Funeral Home, Inc. 3331 Brehms Lane, Balto., Md.						25b. DATE REC'D. BY REGISTRAR APR 12 1983			25c. REGISTRAR'S SIGNATURE <u>George Council</u>				
BP _____													
DHMH - 16 50M 4/82 (VRA 15, 4)													

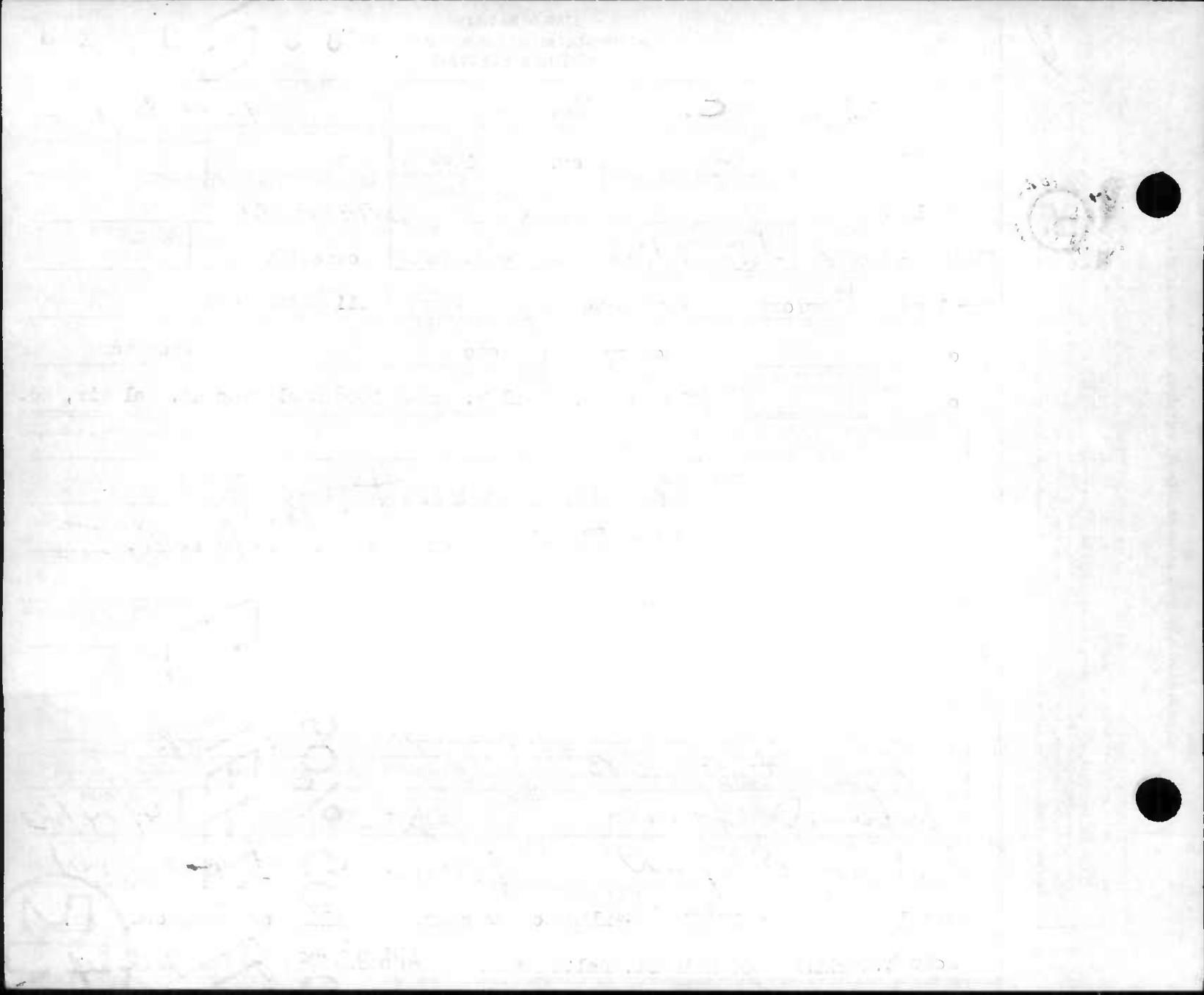
20% SOLUBLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours are required, the physician should retain the certificate until the physician can sign it.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8310728		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH		MONTH	DAY	YEAR	2d HOUR	
Evelyn C. Smith				C.	Smith	Nov.	9	YEAR	4-14-83	1 PM		
3. SEX F			4. RACE W		5. DATE OF BIRTH MONTH Nov. DAY 9 YEAR 1899		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS 0 DAYS		IF UNDER 24 HRS HOURS 15 MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD		10a. CITY OR TOWN OF DEATH HARFORD		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3611 Smith Road		13a. STATE Maryland		13b. COUNTY Harford	
14. FATHER'S NAME FIRST John			MIDDLE		LAST Conner		15. MOTHER'S MAIDEN NAME Rose		16. SOCIAL SECURITY NO. 220-46-4590		17. INFORMANT ADDRESS Paul H. Smith 1008 Shelburne Rd. Bel Air, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: DCVA 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-14-83 to 4-14-83, that (I) (we) last saw the deceased alive on 4-14-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			22b. SIGNATURE John D. Ryan		22c. DEGREE		22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Ryan		22e. ADDRESS Home de Grace, md		22f. DATE SIGNED 4/14/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/17/83		23c. NAME OF CEMETERY OR CREMATORIAL Darlington Cemetery		23d. LOCATION CITY OR TOWN Darlington COUNTY Harford STATE Md.					
24. FUNERAL DIRECTOR NAME John H. Harkins			ADDRESS 600 Main St. Delta Penna		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 20 1983 John J. Canfield							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	1	0	7	2	9
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
<i>SAMUEL Kenneth Streett</i>						4			30	83		4P.M.				
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			Caucasian		MONTH 10 DAY 21 YEAR 12		70			MONTHS	DAYS	HOURS	YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.				Harford County									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Fallston			Fallston Gen. Hosp.		Truck Driver		Self-employed									
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Pylesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3961 Ady Road		21132				
14. FATHER'S NAME FIRST Samuel			MIDDLE Whiteford	LAST Streett	15. MOTHER'S MAIDEN NAME FIRST Bessie		MIDDLE Belle	LAST Scarborough								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 541-32-6741		17. INFORMANT Robert E. Streett		ADDRESS same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> 5860 DUE TO, OR AS A CONSEQUENCE OF (b) <i>chronic pulmonary disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>renal failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs. weeks.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Rael Chew</i>			DEGREE							22c. DATE SIGNED 4/30/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PMR H CHEN</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/3/1983			23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery			23d. LOCATION CITY OR TOWN Madonna			COUNTY		STATE Harford Md.		
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz			ADDRESS Jarrettsville, Md.							25a. DATE REC'D. BY REGISTRAR MAY 3 1983			25b. REGISTRAR'S SIGNATURE <i>John DeLoach</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

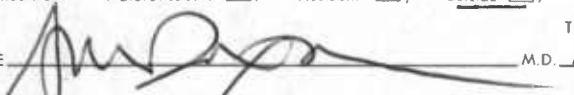
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 / 3 0	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR	
Lawrence C. Tank						April 6, 1983						12 ²⁰ AM M	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White		5 10 07			75			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
Utah			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford County			MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Belair			Belair Nursing Home									electronic eng	
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 715 Walters Mill Rd. 21050		
14. FATHER'S NAME			FIRST William	MIDDLE	LAST Tank	15. MOTHER'S MAIDEN NAME			FIRST Florence	MIDDLE Jane	LAST Crossley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE BETWEEN ONES AND TWO		
no			503-01-9971A		Patricia E. Reider			715 Walters Mill Forest Hill, Md.			Forest Hill, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>													
4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 82</u> , to <u>April 19 83</u> , that (I) (we) last saw the deceased alive on <u>April 4 19 83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Linda Freil</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>April 6 83</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>125 N Main St</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4-6-83			23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem. Pk.			23d. LOCATION CITY OR TOWN Baltimore			STATE Md.	
24. FUNERAL DIRECTOR NAME <u>Lassahn Funeral Home</u>			ADDRESS 11750 Belair Rd.			25. DATE REC'D. BY REGISTRAR APR 11 1983			26. REGISTRAR'S SIGNATURE <u>John J. Connel</u>				

W

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 MAY BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 10731						
1- STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR			2b. HOUR						
(TYPE OR PRINT)			GEORGE TURMAN						<input checked="" type="checkbox"/> DEATH ESTIMATED			4 12 19 83 M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR			
Male		White		Sept. 17, 1931		51 yrs.						4 13 19 83 am			12:03			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia		U.S.A.						<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Harford County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Havre de Grace			Harford Memorial Hospital						Nursing Care Tech.			V.A.M.C., Perry Point						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		ADDRESS								
Maryland		Cecil		Port Deposit		<input checked="" type="checkbox"/>		271 Theodore Road		271 Theodore Road								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Everett			Viola						Laren									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.						17. INFORMANT			ADDRESS						
Yes 2/50 - 12/50			228-34-4376						V. Lorene Turman			271 Theodore Road Port Deposit, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9551 IMMEDIATE CAUSE (a) <u>Shotgun wound of left chest</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
															YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY P.M. 4-12-1983						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home						21f. LOCATION STREET 271 Theodore Rd., Cecil						CITY OR TOWN	COUNTY	STATE	
															Port Deposit	Cecil	Md.	
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.						ADDRESS 111 Penn St., Balto., Md. 21201						DATE SIGNED 4-14-83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Apr. 16, 1983						23c. NAME OF CEMETERY OR CREMATORIAL Honeywell Cemetery						23d. LOCATION CITY OR TOWN Port Deposit			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland															COUNTY Cecil			
															STATE Maryland			
25a. DATE REC'D. BY REGISTRAR APR 19 1983												25b. REGISTRAR'S SIGNATURE John J. Canfield						
DHMH - 17 (VR A15 ME (5))																		
20M 4/82																		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the funeral director's office within 72 hours after death.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					83	10732		
					REG. NO.			
1 - FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			
		MARVIN Dwight Umbarger, Sr.			MONTH DAY YEAR			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		
MALE		White		August 2, 1900		82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia		U.S.A.				Harford County		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bel Air		1204 Churchville Road			Farmer		Agriculture	
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Harford Co.		Bel Air		1204 Churchville Road		
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME				
		JOSEPH NEWTON Umbarger		FIRST MIDDLE LAST		DUOTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (NAME) 838-6894 ADDRESS		APPROXIMATE INTERVAL BETWEEN DEATH AND CERTIFICATION		
NO		219-30-4046-A		Mrs. Margaret C. Umbarger Bel Air, Maryland 21014				
18. CAUSE OF DEATH (Enter only one cause per line for part 1b), and PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								
1629 <i>Cardiopulmonary arrest</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
1629 <i>General debilitation</i>								
1629 <i>Cat cell carcinoma of lung</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) this hospital attended the deceased from <i>March 20 1983</i> to <i>Present</i> that (I) (we) last saw the deceased alive on <i>April 10 1983</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>Robert L. Smith, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>April 21, 1983</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert L. Smith, M.D.</i>		22e. ADDRESS <i>2303 Bel Air Road, Fallston, Maryland 21047</i>		23d. LOCATION CITY OR TOWN		COUNTY STATE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 23, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Meth. Ch. Cem.		23d. LOCATION CITY OR TOWN		
24. FUNERAL DIRECTOR <i>Sheriff William Foster</i> <i>Jayne Willis Foster</i>		ADDRESS <i>W. Broadway & Williams St. Bel Air, Maryland 21014</i>		25a. DATE REC'D. BY REGISTRAR APR 26 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Cawie</i>		

BP _____

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR FURTHER INFORMATION, REFER TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF PUBLIC HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

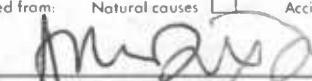
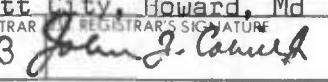
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 83310733		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI. DEATH MATED <input type="checkbox"/>			MONTH	DAY	YEAR	2b. HOUR		
Carl			Stephens	Vogel, Jr.		4	17	1983	M					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR 11:23 pm		
Male	White	Mar. 6, 1934				4. CITIZEN OF WHAT COUNTRY? USA			4	17	1983			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila, Pa.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.								
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) Fallston Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist			12b. KIND OF BUSINESS OR INDUSTRY US-govt.					
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 21 Bonnie Avenue			21014					
14. FATHER'S NAME Carl Stephens			15. MOTHER'S MAIDEN NAME Helen Poor Hoffman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>			16b. SOCIAL SECURITY NO. Korea 206-26-2906			17. INFORMANT Mrs. Virginia Vogel, 21 Bonnie Avenue			ADDRESS Bel Air, Md. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 Arteriosclerotic cardiovascular disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Margarita A. Korell M.D. Assistant MEDICAL EXAMINER												TITLE (SPECIFY)		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			DATE SIGNED 4-18-83								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 21, 1983			23c. NAME OF CEMETERY OR CREMATORIAL West Laurel Hill Cemetery, Philadelphia - Philadelphia			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 21 1983			25b. REGISTRAR'S SIGNATURE					
BP														
DHMH - 17														
(VR A15 ME (5))														
20M 4/82														

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS. AFTER DEATH, IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8310734							
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR	2b. HOUR						
		FRANCIS RAYMOND WALSH				3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.			
						Male		White		MONTH DAY YEAR		40 yrs.		MONTHS DAYS		HOURS MIN.		4 6 1983 M	
		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U S A				8. MARRIED		XX NEVER MARRIED				2c. DATE DECLARED DEAD		MONTH DAY YEAR	2d. HOUR
										WIDOWED		DIVORCED				4 6 1983 D M		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County	
		10. CITY OR TOWN OF DEATH Bel Air				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 213F Crocker Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY Insurance Adjustor-Insur.					
		13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS 213F Crocker Drive 21014							
						YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>											
		14. FATHER'S NAME Francis				MIDDLE J.		LAST Walsh		15. MOTHER'S MAIDEN NAME Elizabeth				Gardiner					
		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 216-42-0725				17. INFORMANT 932B Dunloggin Rd., Ellicott City, Mr. Francis J. Walsh, 21043 Maryland				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9660				IMMEDIATE CAUSE (a) Multiple stab wounds				DUE TO, OR AS A CONSEQUENCE OF									
		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
						(b) _____ DUE TO, OR AS A CONSEQUENCE OF													
						(c) _____													
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
MEDICAL CERTIFICATION		19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR ? P.M. 4-6-1983				Subiect stabbed.													
21d. INJURY OCCURRED WHILE		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				21g. CITY OR TOWN Bel Air, COUNTY Harford STATE Md.									
AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		home																	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>				and in my opinion													
death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 4-7-83									
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/11/83				23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery				23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial										Ellicott City, Howard, Md									
24. FUNERAL DIRECTOR NAME		1630 Edmondson Ave., Catonsville, Md.				25a. DATE REC'D. BY REGISTRAR APR 12 1983				REGISTRAR'S SIGNATURE 									
		Witzke Catonsville Funeral Home, P.A. 21228																	

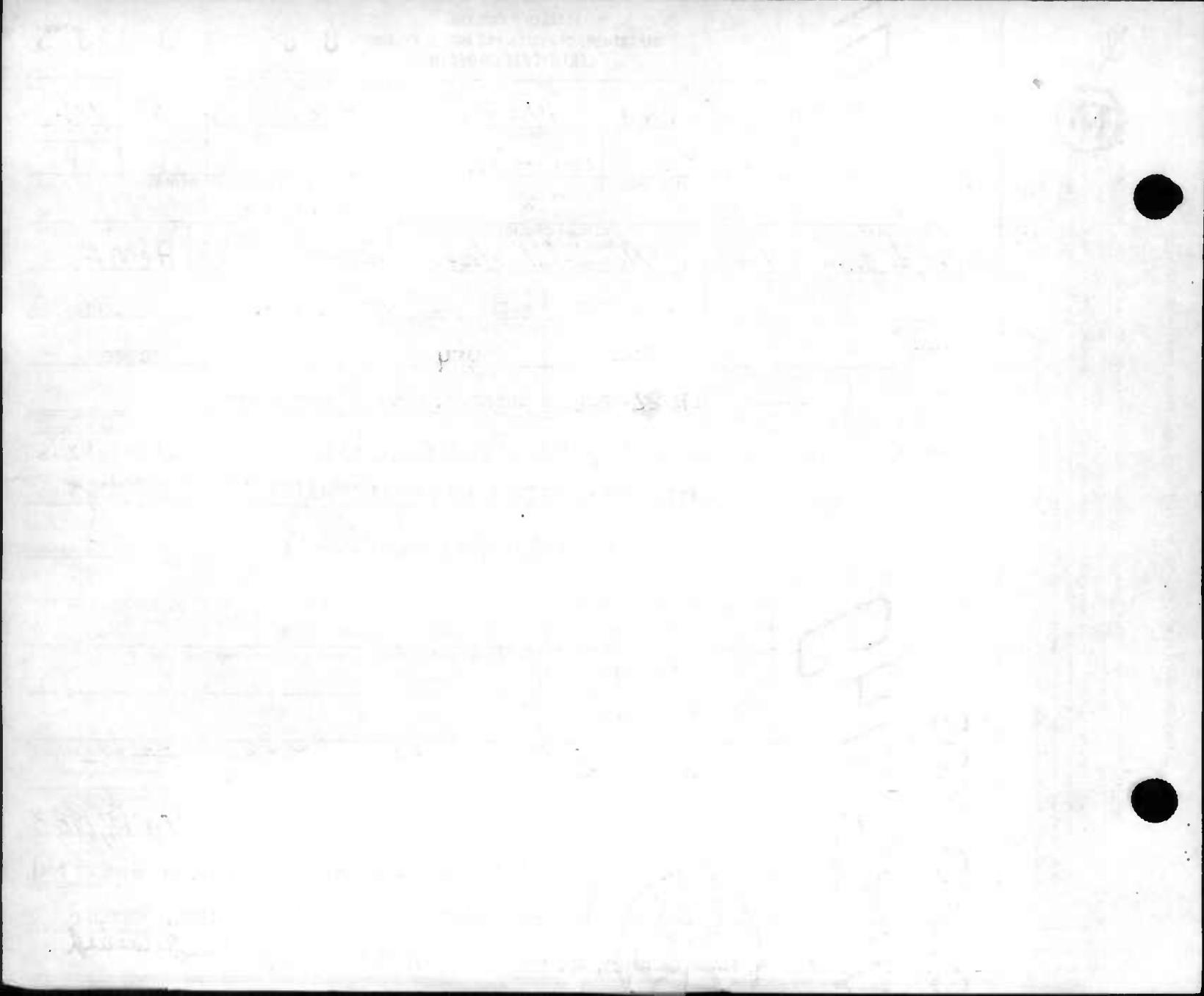
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Ward 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 0 7 3 5		
												REG. NO.		
1. FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Helen DENNA WICKS						April			6	83	15	11 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White			January 21, 1923						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
OHIO			USA						Harford			Havre de Grace		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Havre de Grace			Harford Memorial Hosp			HOMEMAKER						293 WILSON ST.		
13a. STATE MD			13b. COUNTY HARFORD			13c. CITY OR TOWN HAVRE DE GRACE			13d. STREET ADDRESS			21078		
14. FATHER'S NAME FIRST FRANK			MIDDLE KIMBALL			15. MOTHER'S MAIDEN NAME FIRST LUCILLE			LAST SCHMIDT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			272-82-9545			RICHARD A. WICKS			SAME AS #13e			one week		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia														
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular accident (c) Longstanding hypertension														
27 days years														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-10 19 83, to 4-6 19 83, that (I) (we) last saw the deceased alive on 4-6 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Howlett Jackson			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED April 17, 1983					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howlett Jackson M.D.			22e. ADDRESS 1315 Union Avenue Havre de Grace Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE APRIL 9, 1983			23c. NAME OF CEMETERY OR CREMATORIAL WEST NOTTINGHAM CEMETERY			23d. LOCATION CITY OR TOWN			COUNTY STATE		
24 FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME, PA, HAVRE DE GRACE, MD. 21078			25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE APR 11 1983 John G. Lewis											
BP _____														
DHMH - 16 50M 4/B2 (VRA 15, 4)														



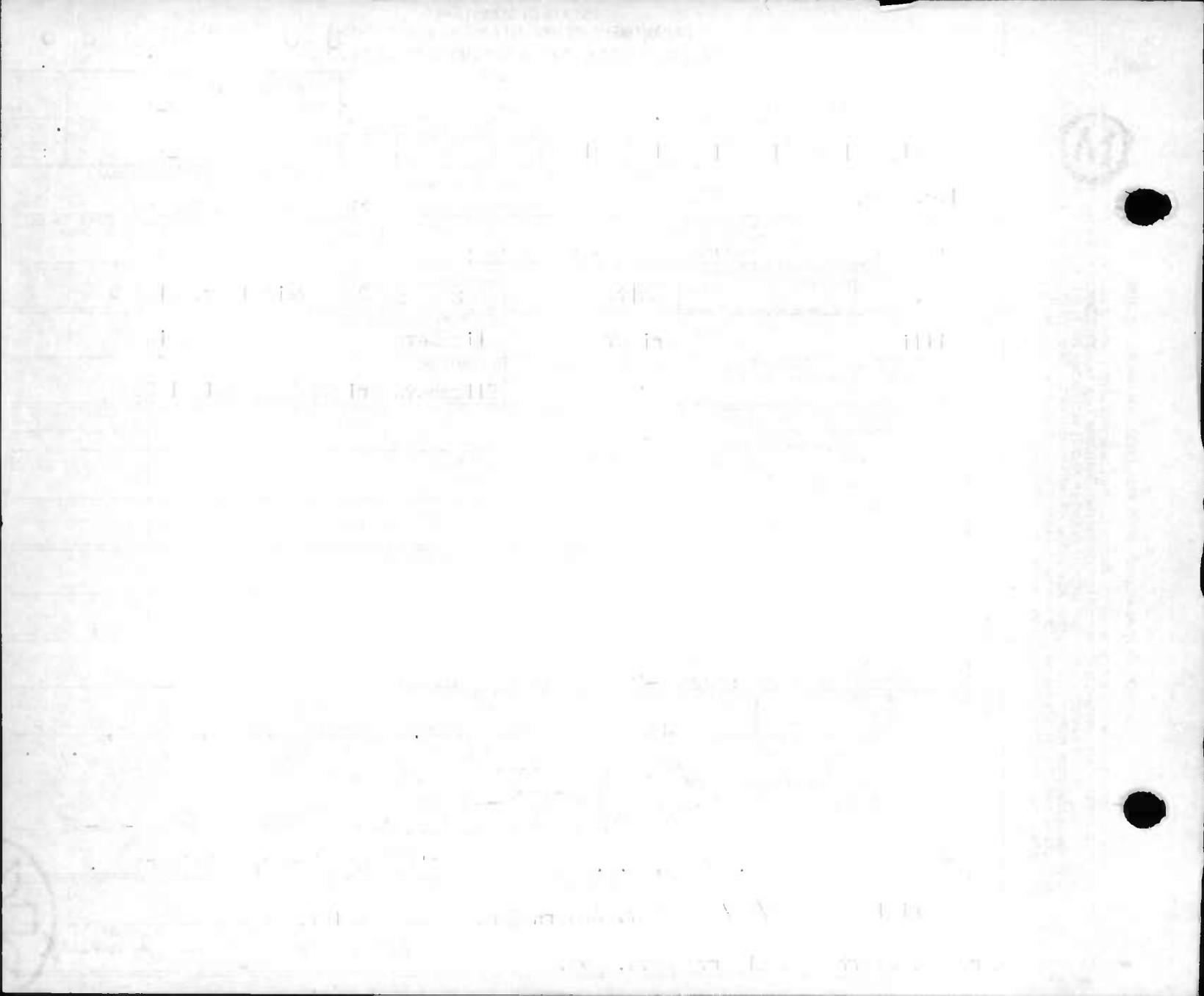
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 1 0 / 3 6

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
		Timothy	G.	Wright	<input checked="" type="checkbox"/>				4-19 19 83 M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY YRS	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	Black	10 1 51	31			4-19	19	83	5:32 p.m.		
7b. CITIZEN OF WHAT COUNTRY?		USA		9. BALTIMORE CITY OR COUNTY OF DEATH							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Fallston		Fallston General Hospital									
13a. STATE Md.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2525 Maisel St. 21230				
14. FATHER'S NAME FIRST William		MIDDLE	LAST Wright	15. MOTHER'S MAIDEN NAME Elizabeth					LAST Chainey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
				Elizabeth Wright		2525 Maisel St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9350 IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF { (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR: 5:00 M. MONTH: 4 MONTH: 4-19 DAY: 19 YEAR: 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hung self							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, FARM, ETC.) cell		21f. LOCATION STREET Harford Co. Detention Center, Bel Air, Harford Co., Md.		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 22b. (SPECIFY) Assistant MEDICAL EXAMINER											
DATE SIGNED 4-20-83											
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.			ADDRESS 111 Penn Street, Baltimore Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 4/23/83		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN Balto. Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS Leroy O. Dyett 4600 Liberty Hgts. Ave.			25a. DATE REC'D. BY REGISTRAR APR 21 1983		25b. REGISTRAR'S SIGNATURE John J. Connelly				



TO HOSPITAL / ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after being signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	10.137
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Cecil</i>	MIDDLE <i>(mn)</i>	LAST <i>Wymer</i>	2a. DATE OF DEATH		MONTH <i>April</i>	DAY <i>3</i>	YEAR <i>1983</i>	2b. HOUR <i>10 AM</i>	
3. SEX		4 RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>June</i> DAY <i>9</i> YEAR <i>1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS <i>61</i>		IF UNDER 1 YEAR MONTHS <i>YRS.</i>		IF UNDER 24 HRS HOURS <i>10</i>		
7a. BIRTHPLACE COUNTRY <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford County</i>		MD.			
10. CITY OR TOWN OF DEATH <i>HARFORD GRACE HARBOR MEMORIAL HOSP.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Civil Service</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>US-govt. Ret.</i>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Bel Air</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>860 Wheel Road</i>		21014			
14. FATHER'S NAME FIRST <i>Riley</i>		MIDDLE <i>--</i>	LAST <i>Wymer</i>	15. MOTHER'S MAIDEN NAME <i>Myrtle</i>		MIDDLE <i>Rose</i>	LAST <i>Cook</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y/N OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>WWII 213-14-3471</i>		17. INFORMANT <i>Mrs. Juanita M. Wymer</i>		ADDRESS <i>21014 Md. 860 Wheel Road, Bel Air</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i> (c) <i>Ischemic Heart Disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-10</i> , 19 <i>83</i> , to <i>4-3</i> , 19 <i>83</i> , that (I) (we) lost sow, the deceased alive on <i>4-3</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <i>4/5/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>125 N. MAIN ST. Bel Air, Md.</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i>		23b. DATE <i>April 6, 1983</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>BelAir Mem. Gardens</i>		23d. LOCATION CITY OR TOWN <i>Bel Air</i>		23e. STATE <i>Harford</i>			
24. FUNERAL DIRECTOR <i>Howard K. McComas III, Abingdon, Md. 21009</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 6 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John G. Carroll</i>							

